

# **STATE TITLE V BLOCK GRANT NARRATIVE**

**STATE: IA**

**APPLICATION YEAR: 2006**

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

See attachment for Assurances and certifications.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

Public input was conducted in several different venues this year. A comprehensive method of public input was used for the Title V needs assessment. Stakeholders throughout the state were involved at three different levels. See the needs assessment section for a more information.

The needs assessment, state priorities, and proposed state performance measures with activities were posted via the Iowa Dept. of Public Health web site. There were approximately 145 hits to the Title V public input section of the web page. Numerous emails were sent to Title V staff to provide comments on the 2006 application.

The MCH Advisory Council members were asked to assist in the establishment of the Title V priority needs and performance measures. The Council endorsed the state plan at their June 9, 2005 meeting. The members were also asked to provide public comment via the IDPH web site for the needs assessment and the state performance measures. The Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned about MCH issues. See the attachment for a list of members and by-laws.

The BFH Grantee Committee is comprised of representatives from local 33 MCH and Family Planning contract agencies. Local contract agencies are encouraged to provide input and influence bureau related policy and quality assurance activities. Input from the committee was used to determine the Title V priority needs and performance measures.

## **II. NEEDS ASSESSMENT**

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

##### Overview

Key factors that provide context for the state's Maternal and Child Health (MCH) annual report and state plan are highlighted in this overview. This section briefly outlines Iowa's demography, population changes, economic indicators, and significant public initiatives. Additionally, major strategic planning efforts affecting development of program activities are identified.

##### Iowa's Land

Most of Iowa is composed of gentle rolling prairies, covered with some of the world's most fertile soil and lies between the high bluffs of the Mississippi and Missouri Rivers. Iowa is one of the United States' most important and prosperous agriculture states and is known as the breadbasket of the country. The deep black soil yields huge quantities of corn, soybeans, oats, hay, wheat, and barley, which help support its cattle and hogs and supplies the large food processing industry. Manufacturing, especially agribusiness, is a large source of income for Iowans.

##### Changes in Demography

Iowa is a rural state with approximately 2.9 million people. According to census projections, Iowa will experience a modest three percent growth in population by 2015. The population will continue to shift from rural areas to urban areas. One-third of Iowa's 99 counties are expected to lose population. Ninety-four percent of the population is white; however, racial and cultural diversity is increasing. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000 and continued to increase to 3.1 percent in the 2003 estimate. Birth data indicate an increase in the Hispanic population. In 2000, live births to Hispanic women made up 5.6 percent of all births, doubling the population proportion in the same year. This ratio is even higher in 2003 (6.6 percent vs. 3.1 percent).

##### Employment and Population Changes

Iowa's unemployment rate has steadily increased since 2000. The 2000 unemployment rate was 2.6 percent and it has increased to 4.8 percent in 2004.

The most notable population change is the increase in Hispanic immigrants. Census estimates show that residents of Hispanic origin increased from two percent in 1998 to three percent in 2004. Iowa's overall population has increased by .4 percent from 2003 to 2004.

Even with the influx of new citizens, Iowa's total population is projected to experience only modest growth between now and 2010. While overall population remains stable, the minority populations are expected to grow in both absolute numbers and total population.

##### Poverty

The percentage of families in Iowa living at or below the federal poverty level has been fluctuating. In 2000 the rate was 10 percent and in 2002 the rate decreased to seven percent. The 2003 data show an increase in the number of families living in poverty to nine percent. This is approximately 260,000 people defined as poor by the federal poverty level. There are 13.4 percent of children 0-17 years old who are living at or below the federal poverty level.

##### Community Empowerment Areas

Iowa has been progressive in implementing partnerships between local and state government. In 1997, legislation provided for the establishment of "innovation zones." Several state agencies collaborated with local organizations within approved zones to reduce barriers to services as identified by communities. In 1998, legislation was passed which built upon the "innovation zones" concept to promote "empowerment" areas. The purposes of Community Empowerment legislation were to establish local community collaborations, create a partnership between communities and state government, and improve the well-being of children 0-5 years of age and their families. An additional goal was to empower communities to build a system of services to improve the effectiveness of local

education, health, and human services programs. Community empowerment areas have been designated to cover all 99 counties. This legislation directly influences local MCH services in Iowa.

In 2002, Community Empowerment convened the core stakeholder group to gather input on the visions, goals, indicators, and strategies for an early care, health, and education framework. The purpose of the stakeholder group is to be an advisory group to the early care, health, and education system. The stakeholders include representatives from public and private entities throughout the state. The functions of the stakeholder group is to review, design, and participate in cross functional proposals, understand all parts of the system, create and update plan, agree on common language for the system, develop a menu of best practices, encourage relationships across disciplines, and be a resource to the system.

Community Empowerment held regional sessions with over 250 stakeholders for input on the goals and indicators. The core stakeholders reconvened and reviewed all the input from the regional meetings, built solid support for goal statements, and began to define strategies.

The Bureau of Family Health in partnership with Community Empowerment developed an early childhood plan through the HRSA Early Childhood Comprehensive Systems grant. Key personnel from IDPH are the project director and coordinator. The State Empowerment Team will serve as the coordinating body of the grant. The Early Childhood Iowa Stakeholders will serve as the advisory body to the grant. The plan will promote the development of community-based comprehensive systems of services that assure coordinated, family centered, and culturally competent care for children.

The Early Childhood Iowa Stakeholder group developed the Iowa Early Care, Health, and Education Strategic Plan. The stakeholder members are responsible for taking the goals, indicators, and strategies back to their constituents to get buy-in. The Iowa Department of Public Health applied for a three-year implementation grant in May 2005.

The Early Childhood Iowa Stakeholder members have developed six component workgroups to help move the system planning forward. The six component workgroups are:

1. Quality services and programs;
2. Public engagement;
3. Resources and funding;
4. Results accountability;
5. Governance and Planning; and
6. Professional Development.

More information on the Early Care, Health, and Education System building activities can be found at [www.earlychildhoodiowa.org](http://www.earlychildhoodiowa.org).

#### 2005 Legislative Session for Early Childhood

The legislative session wrapped up on Friday, May 20th. Preliminary results indicate an additional spending of over \$21.1 million for early childhood education and an additional spending of \$10.4 million for Community Empowerment and \$10.75 million for child care. Below are a few of the highlights for the child care dollars:

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- Implement a quality rating system;
- Raise reimbursement rates for child care providers to the 2002 Market Rate Survey (effective September 1, 2005);
- Raise the child care subsidy eligibility for families from 140 percent to 145 percent of the Federal Poverty Level (effective September 1, 2005); and
- Raise the child care subsidy eligibility for families of children with special needs to 200 percent of the Federal Poverty Level.

Some of the specifics affecting Community Empowerment Areas include:

\$4.65 million of the State General Funds are targeted to support low income preschool tuition; and

\$1 million will support professional development activities between the Iowa Empowerment Board, community colleges and the area education agencies.

#### Newborn Hearing Screening Program

For the past several years, the IDPH has taken a leadership role in establishing a quality system for Early Hearing Detection and Intervention (EHDI) in Iowa. In January 2004, Iowa implemented EHDI legislation that mandates every newborn be screened for hearing loss prior to hospital discharge and that the screening results be reported to IDPH within six days of the child's birth. The legislation also requires that the results of any rescreens and diagnostic assessments be reported to IDPH for any child under three years of age.

On April 1, 2005, the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources and Service Administration (HRSA) awarded an Early Hearing Detection and Intervention grant to the state of Iowa. This grant was awarded to Child Health Specialty Clinics (CHSC). The award provides \$139,000 each year for the three-year period of April 2005-March 2008.

The activities of this grant focus on reducing the number of infants who are "lost" in the system; therefore, delaying the provision of early intervention services. The five goals identified in this grant are:

1. All newborns will be screened appropriately prior to hospital discharge.
2. All audiologic diagnoses will occur before children are three months of age.
3. All eligible children will be enrolled in an early intervention program (Part C, Early ACCESS) before six months of age.
4. All families with children 0-3 who are deaf or hard-of-hearing or are at risk for late-onset hearing loss will be linked to a medical home.
5. All families with children 0-3 who are deaf or hard-of-hearing will receive family-to-family support.

The IDPH recently entered into a three-year cooperative agreement with the Centers for Disease Control and Prevention. The activities of this agreement focus on developing and implementing a statewide EHDI surveillance system. The goals of the project are to:

1. Complete the statewide implementation of the EHDI data system.
2. Facilitate data integration linkages with related screening, tracking, and surveillance programs.
3. Maximize the use of EHDI data for statewide and local decision-making.
4. Evaluate the Iowa EHDI system based on the performance indicators set forth in the National EHDI Goals and utilize the results to establish project sustainability. More information can be found in the population based capacity section of the needs assessment.

#### Perinatal Guidelines

The 1998 Legislature directed IDPH to develop and maintain statewide perinatal guidelines. State guidelines were available previously; however, the new administrative rules were written with input from the public and the Perinatal Advisory Committee. These rules, effective March 17, 1999, allow for voluntary participation by the hospitals. The Guidelines provide the framework to be used in defining and evaluating the level of perinatal services being offered. It also outlines the steps and process for a hospital to be reviewed for a new designation. Facilities that provide hospital care for obstetrics and newborn infants are classified on the basis of functional capacities and organized within a regionalized system of perinatal care. This regionalized system of perinatal care helps ensure that each newborn infant is delivered and cared for in a facility appropriate for his or her health care needs and to facilitate the achievement of optimal outcomes. The functional capabilities of facilities that provide inpatient care for obstetrics are classified from basic to comprehensive services. (Level I, II, IIR, III)

#### State Child Health Insurance Program

In response to the federal initiative of State Children's Health Insurance Programs (SCHIP), the 1998 Iowa Acts, Chapter 1196, authorized health care coverage for specified uninsured children in Iowa. Legislation created a plan that expanded Medicaid eligibility to children whose family incomes were up to 133 percent of the federal poverty level. Iowa also chose to establish a separate private

insurance plan for children with a family income between 133 percent and 200 percent of the poverty level; this program is called hawk-i (Healthy and Well Kids in Iowa.)

In July 1999, the Family Health Bureau became a Robert Wood Johnson Foundation (RWJF) grantee for Iowa's Covering Kids project. The projects focused on three goals: 1) design and conduct outreach programs in pilot communities to help identify and enroll children into Medicaid or hawk-i; 2) simplify the enrollment and renewal process and 3) coordinate existing coverage programs for low-income families. The Covering Kids grant ended in 2002. However, RWJF extended the grant entitled Covering Kids and Families (CKF) that builds on Covering Kids efforts. On July 1, 2005, Iowa's CKF will begin the fourth year of the project. Priorities for year four include: engaging school districts to accept a central role in assuring health care coverage for children; developing suggested guidelines and materials to support the role of health care professionals in providing consumer education on health care coverage; identifying and analyzing barriers to enrollment and renewal and make comprehensive policy and program recommendations for removing barriers; and assuring coordination of state level and community based enrollment efforts.

In addition to the CKF project, the Bureau of Family Health became the contractor with DHS for providing state level hawk-i outreach in 2002. A full-time state hawk-i outreach coordinator provides outreach coverage for state level initiatives and the local child health agencies provide outreach coverage for all 99 counties at a local level. The local coordinators focus outreach on faith based organizations, schools, health care providers, and special populations while working with key stakeholders on outreach initiatives.

#### Fit for Life

The Iowa Department of Public Health was awarded CDC funding to address nutrition and physical activity to prevent obesity and other chronic diseases. The funding is intended to build the state's capacity to address the epidemic of overweight and obesity. Currently the focus is building partnerships to write a comprehensive state plan for nutrition and physical activity. The Iowans Fit for Life Partnership will assist with writing the six components of the state plan; educational settings, early childhood, older Iowans, business and agriculture, health care, and community. More information can be found at: [www.state.ia.us/iowansfitforlife/](http://www.state.ia.us/iowansfitforlife/)

#### MCH Data Use Academy/Great Plains Public Health Leadership Institute

Iowa MCH programs have partnered with resources beyond the state's borders to increase capacity to serve the Title V population. By using MCHB State System Development Initiative grants for seed money and collaborating with additional funding partners, IDPH provided scholarships for local MCH leaders to attend the Data Use Academy (DUA) offered by the University of Nebraska Medical Center (UNMC). The last two teams finished the yearlong training in October 2004 with a graduation conference held in Omaha. The DUA team, Methamphetamine-Prevention Task Force, was especially successful. The team's goal was to increase the knowledge level of youth (grades 5-8) regarding the devastating effects of methamphetamine in a fun, interactive learning environment. The project was featured with a poster presentation at the annual statewide Iowa Public Health Conference in March 2005.

The Data Use Academy at UNMC was discontinued after the October 2004 graduation. A new learning strategy is under development by UNMC staff and Iowa's DUA cohort is participating in the planning process. The proposed Great Plains Public Health Leadership Institute will provide a yearlong learning opportunity for individuals instead of teams. Iowa's MCH community, at the state and local level, intends to take advantage of this new capacity building opportunity.

#### Building Healthy Communities in Iowa through Harkin Wellness Grants

In May 2005, the Iowa Department of Public Health issued an RFP to local Iowa communities for 36 Building Healthy Communities in Iowa through Harkin Wellness Grants. Examples of eligible community organizations are counties, cities, schools, tribes, health departments, and philanthropic organizations. The goals of the grants are to plan and promote individual and community health and wellness, prevent the incidence of chronic disease, and sustain these efforts into the future.

The RFP explains that building healthy communities in Iowa will not happen by accident or through a single program, but through a comprehensive, community-based approach. Five components of a process to build healthy communities are described as:

1. Strengthening the grassroots effort to address the communities' health and quality of life issues,
2. Embracing a process that will determine a measure of where the community is (assessment) and where it should go (vision),
3. Maintaining the commitment of key partners by engaging them in specific strategies that can move the community toward the vision,
4. Promoting structural and systematic change that will result in health and quality of life improvements, and
5. Maximizing limited resources and leveraging additional resources including possible redirection of resources to areas that help the community achieve the vision.

The project period is from October 21, 2005 to June 30, 2007. First year funding will be awarded at three levels consistent with the demographics of the community, demonstrated needs, and scope of the project. For the first year, the RFP offers 20 level I awards (valued at <\$75,000), 12 level II awards (valued at \$75,001-\$150,000), and four level III awards (valued at \$150,001-\$250,000). Applications for the Building Healthy Communities in Iowa through Harkin Wellness Grants are due to IDPH on August 15, 2005.

#### Children with Special Health Care Needs

Child Health Specialty Clinics (CHSC) is Iowa's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN). The CHSC administrative office is located at the University of Iowa in Iowa City. Including the Iowa City office, CHSC currently supports 13 regional centers throughout the state. Regional centers provide and manage a number of services for CYSHCN: direct care clinics, care coordination, family support, and infrastructure building services, including core public health functions (assessment, policy development, and assurance), training, program evaluation, and quality improvement. Additionally, the CHSC Director, Jeffrey Lobas, M.D., works collaboratively with the state MCH Director, Early ACCESS (IDEA, Part C) Coordinator, and the Medicaid Director to implement and develop programs to meet the health-related needs of all Iowa children. The collaboration is enhanced by Dr. Lobas's 0.2 FTE appointment as medical director for the Division of Health Promotion and Chronic Disease Prevention of the Iowa Department of Public Health.

Organizational capacity has varied over the previous five-year program cycle. The Title V MCH Block Grant reformulation, state de-appropriations, and then re-appropriations, have demanded annual "scenario planning" activities by program leadership. As a result, both hours of operation and array of service offerings have fluctuated. When services such as cardiology, gastroenterology, and community-based nutrition consultation for CYSHCN have been decreased or eliminated, CHSC works to assure that resulting service gaps are minimized. When new grants or contracts are obtained, consideration is given to the sustainability of new initiatives or services.

The process for developing CHSC priorities uses a combination of structured problem identification and prioritization activities, web-based public input opportunities, and program leadership strategic planning efforts. In formulating program priorities, consideration is given to national priorities, emerging issues, financial circumstances, collaborative opportunities, and overall environmental fluctuations. Input into program planning decisions is sought from CHSC program staff, state and local contract MCH stakeholders, and families of CYSHCN. Legislators, though generally not involved in program planning, are kept informed of major program activities that benefit their constituents. Program planning and priority setting has been supplemented by data from the 2000 Iowa Child and Family Household Health Survey and the National Children with Special Health Care Needs Survey (2001). Both are random sample, population-based surveys that are scheduled to be repeated in the next year or two. Repeated surveys will provide information about changes in family experiences over time. In keeping with current high-level interest in early childhood health and development, the next version of the Iowa Child and Family Household Health Survey, scheduled for 2005, will have a special focus on early childhood issues.

The population-based surveys, in combination with the problem identification and prioritization activities, have identified a number of issues important to CYSHCN and their families. Consistent with national priorities, these include child and adolescent mental and behavioral health; medical homes for CYSHCN; organization and coordination of services for families; early identification and referral; transition systems for adolescents with special health care needs; family involvement in program activities; and adequate coverage for needed services. Underlying all these issues is a continuing challenge to define CHSC's roles in addressing identified priorities in a limited resources environment. Possible roles, for example, include leadership, facilitation, participation, direct service provision, resource support, and advocacy.

More and more, CHSC self-identifies as an organization dedicated to infrastructure building for the purpose of system development. Infrastructure building efforts currently receiving the greatest attention include improving access to pediatric mental and behavioral services and spreading the medical home model to improve quality of care for CYSHCN. To assure success in system development, CHSC is incorporating program evaluation, health services research, economic analysis, and partnership building strategies--all with an eye to positively influencing policymakers.

## **B. AGENCY CAPACITY**

In Iowa, Title V administration is the responsibility of the Bureau of Family Health (BFH) at the Iowa Department of Public Health. The Iowa legislature directs IDPH to work jointly with Child Health Specialty Clinics (CHSC) at the University of Iowa to serve children and youth with special health care needs. Section IIIC describes the organizational structure of these organizations. Iowa's MCH programs promote the development of systems of health care for children ages 0 to 21, pregnant women, and their families. Iowa strives for services that are collaborative, comprehensive, flexible, coordinated, culturally competent, developmentally appropriate, family-centered, and community-based. The core public health functions of assessment, policy development, and assurance are promoted.

### **PREVENTIVE AND PRIMARY CARE FOR PREGNANT WOMEN, MOTHERS, AND INFANTS**

#### **Women's Health Team**

Members of the BFH Women's Health Team have extensive experience working with women of childbearing age. The Women's Health Team provides direction, oversight, and monitoring for the 30 local maternal health and/or family planning contract agencies that provide services in Iowa. System development activities are coordinated with the IDPH Family Planning Program, the Family Planning Council of Iowa, hospitals, schools, local boards of health, providers of adolescent health programs, and statewide women's health initiatives. Technical support is provided to local maternal health and family planning agencies. Contracts are managed with the University of Iowa Hospitals and Clinics (UIHC), Department of OB/GYN, and Department of Pediatrics. The MH Community Health Consultant coordinates activities with the Healthy Start Project managed by Visiting Nurse Services of Des Moines.

#### **Maternal Health Centers**

Twenty-five local maternal health contract agencies provide services to all 99 counties in Iowa. The maternal health map can be located at [http://www.idph.state.ia.us/hpcdp/pdf/mh\\_map.pdf](http://www.idph.state.ia.us/hpcdp/pdf/mh_map.pdf). Local maternal health agencies provide prenatal and postpartum care to low-income women and other women in need. Services include risk assessment, psychosocial screening, referrals, care coordination, education, delivery planning, postpartum visits, and presumptive eligibility for Title XIX. Outreach efforts include community-based strategies for hard to reach populations, with special emphasis on informing residents of available services. Modes of delivery of the medical components of prenatal care include traditional clinic settings, purchase of services from private practitioners, and agreements with local hospitals. Performance standards have been developed to ensure the provision

of quality maternal health service throughout the state. Maternal Health agencies also complete a Quality Assurance Matrix evaluating the provision of enhanced services and conduct direct care chart audits on an annual basis.

#### Statewide Perinatal Care Program

The Statewide Perinatal Care Program provides training of health care professionals, development of care standards, consultation for regional and primary providers, and evaluation of quality of care through the state's 84 hospital facilities that provide obstetrical and newborn services. The team consists of a neonatologist, a perinatologist, a dietitian, an obstetrical nurse, and a neonatal intensive care nurse. Through a contract with the University of Iowa Hospitals and Clinics, these services are provided to all hospitals that perform deliveries; more intensive services are directed toward Iowa's three tertiary care centers and 19 secondary care centers. Quarterly, the team also publishes two newsletters. "The Iowa Perinatal Letter" for health care providers and "The Progeny" for perinatal nurses. The publications are used for general prenatal education and to disseminate information.

#### Des Moines Infant Mortality Center Consortium

The mission of the Consortium is to improve birth outcomes and to reduce infant mortality by enhancing maternal child health interventions to vulnerable populations. One of the consortium goals is to enhance partnerships between state and local government, maternal and infant health care providers, and the private and public sector to provide integrated community-based care for pregnant women and their infants. The consortium includes physicians, nurses, social workers, community leaders, and legislators. The consortium is a collaboration between the Iowa Department of Public Health, Visiting Nurse Services of Polk County, and Healthy Start. The Visiting Nurse Services of Polk County holds the Healthy Start Grant to Eliminate Disparities in Perinatal Health. Strategies include outreach and recruitment efforts directed toward identifying and engaging pregnant women in services in the first trimester of pregnancy, family development, home-based case management, health education, depression screening, and community support services. All vulnerable minority populations are included in the targeted population for the Polk County Healthy Start Program; however, a specific emphasis was placed on the African American and Hispanic/Latino populations due to infant mortality rates in the identified project area. The consortium continues to work with Polk County Healthy Start to continue to address the significant disparities in infant mortality.

#### Abstinence Education

IDPH applied for federal funding through Section 510 and Community Based Abstinence Education (CBAE), formerly SPRANS, of Title V of the Social Security Act. Section 510 will secure contractors through a competitive Request for Proposal (RFP) to provide abstinence education programming throughout the state. Programming may include curriculum-based programs, community involvement activities, mentoring, media campaigns, positive youth development, workshops, informational programs, parent involvement, and peer education. CBAE will fund three community-based agencies, selected through an RFP, to provide programming through curriculum-based instruction, community involvement, and mentoring components. Evaluation of each program will be conducted.

#### Healthy Families Iowa

The Healthy Families Iowa program is named Healthy Opportunities for Parents to Experience Success (HOPES). It is a comprehensive home visiting program designed to promote healthy, safe and self-sufficient families. Twelve of the 13 state funded HOPES programs have been awarded the national Healthy Families Credentials, which assures the services are provided at the national researched and proven level of quality. Pregnant women or families with a newborn are screened for risk factors indicating poor outcomes for the children and family. HOPES is offered to the families at high risk and participation is voluntary.

### PREVENTIVE AND PRIMARY CARE FOR CHILDREN

#### Child Health Advocacy Team

Members of the Child Health Advocacy Team have extensive experience working with child and adolescent health issues. The team provides direction and oversight to 25 local child health contract

agencies covering all 99 counties in Iowa. The map of Child and Adolescent Health Services for Iowa is located at [http://www.idph.state.ia.us/hpcdp/pdf/ch\\_map.pdf](http://www.idph.state.ia.us/hpcdp/pdf/ch_map.pdf). Program activities include cooperative efforts with the Oral Health Bureau, Bureau of Disease Prevention and Immunization, Bureau of Lead Poisoning Prevention, Bureau of Nutrition and Health Promotion, Center for Congenital and Inherited Disorders, Early ACCESS (IDEA, Part C), Early Hearing Detection and Intervention, Empowerment, Early Care, Health, and Education System, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Adolescent Health, Family Planning, Healthy Child Care Iowa, Assuring Better Child Health and Development Project (ABCD II), Covering Kids and Families, hawk-i Outreach, Head Start, and the Asthma Control Program.

### Child Health Centers

Twenty-five local child health contract agencies provide services to all 99 counties in Iowa. Child health agencies are charged with developing health programs that are responsive to community needs. The MCH Performance Standards described previously are used to ensure the provision of quality child health services throughout the state. The child health agencies focus on infrastructure building, population-based services, and enabling services to assure that children have access to regular and periodic well child screening services. Other activities of contract agencies include outreach for uninsured children, providing education to families about available services, assuring medical homes, providing direct care services where access is limited, improving oral health access, promoting health and safety in child care settings, coordinating with the Early ACCESS program, and making appropriate referrals.

### Oral Health Program

The Oral Health Bureau (OHB) promotes access to dental care and preventive health behaviors to reduce the risk of oral disease. In addition to administering programs such as the school fluoride mouth rinse, school-based dental sealant, and dental care for persons with disabilities, the OHB staff offers consultation and assistance to MCH agencies in assuring good oral health for the women and children they serve. CH agencies receive Title V funding to be used in three ways: to provide limited preventive and restorative dental care for their uninsured or underinsured clients through agreements with local dentists; for infrastructure-building activities; and/or to pay for costs associated with dental hygienist services. CH agencies also receive money for the Access to Baby and Child Dentistry (ABCD) program, to be used to improve oral health status and increase access to dental homes for Medicaid-enrolled children. Both maternal and child health clients receive direct preventive care from dental hygienists (e.g., fluoride varnish applications and screenings) in more than half of Iowa's 99 counties, primarily in WIC clinics.

OHB staff also collaborates with several private and public organizations to improve access to oral health care. Partners include the University of Iowa College of Dentistry, Delta Dental Plan, the Iowa Dental Association, the Iowa Dental Hygienists' Association, the Head Start Association, DHS, the Iowa-Nebraska Primary Care Association, the Iowa Rural Development Council, the University of Northern Iowa, and the Iowa Prevention of Disabilities Policy Council.

### Healthy Child Care Iowa

Iowa has 79 child care nurse consultants CCNC (the term was changed from child care health consultant to child care nurse consultant to more describe to consumers the scope of practice of the consultant). Training is offered annually to registered nurses entering a consultant role with early care and education businesses. Five full-time regional CCNCs have communication and mentoring responsibilities for the part-time CCNCs in their region. Funding for CCNC positions comes from Child Care Developmental Funds, state Empowerment funds, and Head Start/Early Head Start. Iowa's Title V grants to local MCH agencies require the local agency to support a registered nurse as 0.5 FTE child care nurse consultant. Agencies use a variety of strategies to fulfill this requirement. Child Care Nurse Consultants conduct on-site assessments and technical assistance, training, and respond to requests for information. An encounter-based activity logging system was field-tested. Quality improvement instruments were completed, field-tested, and readied for dissemination.

### Child Death Review Team

The Iowa Child Death Review Team (CDRT) reviews medical, investigative, and medical examiner records of all Iowa children from birth through 17 years of age who died during the previous calendar year. CDRT recommendations to prevent future deaths are made annually to the Governor, legislature, state agencies, and the public.

#### Sudden Infant Death Syndrome Program

Autopsies are required by Iowa Code on all children two years and younger who die unexpectedly. A contractual agreement with the Iowa SIDS Foundation covers printed information, community and professional presentations, grief counseling, and referral services. Grief counseling is provided within the county of death by public health nursing staff. A peer contact provides assistance to the family through the first year of grief following the infant's death. The Iowa SIDS Foundation operates eight grief support groups across the state.

#### Genetic Program

In 2004, state legislation was passed that renames the Birth Defects Institute and some of its programs. The Institute is now called the Center for Congenital and Inherited Disorders (CCID). Programming from the CCID includes: Iowa Registry for Congenital and Inherited Disorders (formerly the Birth Defects Registry), Regional Genetic Counseling Services, Iowa Neonatal Metabolic Screening Program (INMSP), Maternal Serum Alpha-fetoprotein (MSAFP) screening program, and the Neuromuscular and Related Disorders program.

With the possible addition of Cystic Fibrosis carrier screening as part of the MSAFP and Cystic Fibrosis screening as part of the INMSP (pending successful pilots), the genetics program staff has been working closely with the Pulmonology and Allergy Department staff at the University of Iowa.

The Center is also participating in the Heartland Regional Neonatal Screening and Genetics Collaborative that serves eight states in the Midwest. The Center is promoting the U.S. Surgeon General's Family Health History initiative through educational presentations and public service campaigns.

#### Early Hearing Detection and Intervention

The Iowa Department of Public Health and Child Health Specialty Clinics direct the state's Early Hearing Detection and Intervention (EHDI) efforts. IDPH has entered into a new three-year cooperative agreement with the Centers for Disease Control and Prevention to improve the state's capacity to collect and track hearing-related information for children 0-3. On April 2005, CHSC entered into a three-year EHDI grant with MCHB. The purpose of the MCHB project is to assure that all infants and toddlers who are identified as deaf or hard of hearing receive timely and appropriate follow-up services.

#### Iowa Collaboration for Youth Development (ICYD)

The Collaboration is a partnership of state and local entities concerned about youth and youth policies. This interagency initiative is designed to better align state policies and programs and to encourage collaboration among multiple state and community agencies on youth-related issues. The goals of the initiative are to promote the use of positive youth development principles in state policies and programs and to facilitate the use of effective youth development practices in communities.

IDPH is an active partner in the ICYD. The Interagency Steering Committee for the ICYD has endorsed the concepts and principles put forth in the design for "Enhancing Iowa's Systems of Supports for Learning and Development". This document introduces a set of new concepts for systems of supports that students need if they are to achieve at high levels. The document calls for rethinking the directions for student supports in order to reduce fragmentation in the system and increase the effectiveness and efficiency by which it operates. The intended results are for all children and youth to succeed in school, grow up healthy and socially competent, and prepared for productive adulthoods.

#### Prevention of Youth Violence

Iowa's primary focus is to strengthen prevention of self-directed and interpersonal child and adolescent violence. These include such behaviors as suicide, child maltreatment, school violence, community violence and bullying. Comprehensive and sustained support of youth is necessary to improve youth outcomes and reduce suicide and interpersonal violence. The overarching theme of the violence prevention effort will be youth development. Youth development goes beyond problem reduction and applies to prevention, remediation and treatment, participation and involvement, and academic and workforce preparation.

## CULTURALLY COMPETENT CARE FOR MCH POPULATIONS

The Office of Minority Health was renamed to the Office of Multicultural Health and remains under the direct supervision of the Division Director in the Division of Health Promotion and Chronic Disease Prevention. The Office continues to increase the capacity to provide training to local MCH agencies on cultural diversity/sensitivity and health disparities and educational awareness workshop presentations at local and statewide MCH related conferences and seminars.

The Office of Multicultural Health Consultant serves as a resource person for IDPH programs, especially those programs with strategies, goals and objectives to address the needs of women, children and families of our minority, immigrant and refugee populations. Resources are inclusive of, but not limited to, educational materials, outreach, and networking to access for services, community stakeholders and networks, curriculum training design, and instruction. During the past year, the Office was available to the 99 counties for assistance with the community health needs assessment and health improvement plan (CHNA & HIP).

### Minority Health Advisory Board

The Minority Health Advisory Board is currently being examined for reactivation. Although it has not formally met within the last year due to reconstruction of IDPH advisory boards, the Office of Multicultural Health Consultant maintains an open line of communication and networks with the statewide membership, which has representation from the African American, Latino, Asian/Pacific Islander, Native American, refugee, and immigrant populations.

### Local Minority Health Coalitions

The Office of Multicultural Health entered into agreement with the Polk County Minority Health Coalition Infant Mortality Subcommittee and produced the Polk County Health Infant Mortality Video specifically targeted to decrease the disproportionate rates of infant mortality in the African American community. The video is distributed to local agencies, faith based, and community programs. The Office continues to play an active advisory and participatory role for the Woodbury County, Black Hawk County and Polk County Minority Health Coalitions.

## CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Child Health Specialty Clinics (CHSC) uses an organizational structure of 13 regional centers to provide family-centered, community-based, coordinated services to Iowa children and youth with special health care needs (CYSHCN) and their families.

### Direct Clinical Services

The Integrated Evaluation and Planning Clinic (IEPC) is CHSC's cornerstone direct clinical service. It is a multidisciplinary service located in all CHSC regional centers. The IEPC primarily evaluates and makes recommendations for children with behavioral and emotional problems. As a major community-based resource for children with behavioral and emotional problems, IEPCs are an important platform for family access to intensive care coordination, as well as to child psychiatry consultation via telehealth communication modalities. IEPC staffing includes some or all of the following: an advanced registered nurse practitioner or nurse clinician, a contracted medical consultant, an Area Education Agency psychologist and/or speech and hearing professional, a contracted or Department of Human Services social worker, and a parent consultant. Most children seen in an IEPC have complex behavioral or emotional problems that are not successfully addressed by parents, educators, or

primary care physicians. The IEPCs provide a cost-effective resource to evaluate and monitor treatment for these children within their local communities. IEPCs are a resource for children and families who face challenging contemporary health and social problems, for example, children with major behavioral or emotional problems; children affected by exposure to drugs during pregnancy or later at home; children subjected to abuse or neglect; and children experiencing the uncertainties and instabilities of foster care.

The Birth to Five Program is CHSC's direct clinical service contribution to Iowa's early childhood service system. Birth to Five services are located in all CHSC regional centers. The Birth to Five Program provides developmental screening, assessment, and follow-up for young children who are at-risk for developmental delay. Recommendations and family support are provided, as is care coordination, if needed. Advanced registered nurse practitioners with extensive expertise in the care and management of young children with special health care needs are the providers. The Birth to Five Program collaborates closely with Iowa's Part C (of IDEA) Program and local primary care providers. Children seen in the Birth to Five Program have or are at risk for developmental problems that can affect their ability to grow, learn, and perform. The Birth to Five Program assures children and families that problems will be detected and early intervention services arranged. Assuring healthy development in the early childhood years is a growing and widely accepted priority among child advocates and service providers. The Birth to Five Program is a cost-effective program that complements the services of Iowa's primary care health providers and early intervention staff. Children served by the Birth to Five Program include children who are at risk for developmental delay in the areas of growth, motor skills, language, and social interaction; children subjected to abuse or neglect; and children affected by exposure to drugs during pregnancy or later at home.

#### Care Coordination Services

CHSC's Health and Disease Management (HDM) Unit, composed of both nurse professionals and parent consultants, is designed to help families evaluate a child's needs and obtain services. Since 1985, CHSC has had an agreement with the Iowa Department of Human Services (DHS) to assist with care coordination of CYSHCN eligible for the Medicaid Home and Community-Based Services III and Handicapped Waiver. Now, care coordination is provided for children enrolled in Medicaid's consolidated Waiver Program. The number of CYSHCN enrolled in Waiver Programs served by CHSC's HDM Unit depends on the amount of Medicaid funds available to provide care coordination services.

General care coordination also is available for CYSHCN and families enrolled in the direct care IEPCs or Birth to Five Program. For children with significant behavioral health problems, an especially intensive care coordination effort is being offered. A health services research project is being proposed to document child, family, and system outcomes related to this more intensive care coordination.

The Continuity of Care Program is a care coordination service to improve linkages and outcomes for CYSHCN discharged from the Children's Hospital of Iowa (at the University of Iowa) to community-based services.

A major new care coordination initiative will facilitate linkages of all primary care practices in the state, pediatric and family medicine to community-based care coordination resources, most of which will be affiliated with the Title V Program. This initiative is part of an MCHB-supported integrated systems development grant.

#### Family Support Services

CHSC offers family-centered services based on the recognition that the family is constant in the child's life while the service system and its personnel fluctuate. Family-centeredness honors the racial, ethnic, cultural, and socioeconomic diversity of families. The CHSC Parent Consultant Network (PCN) is affiliated with the CHSC regional centers and utilizes parents of CYSHCN to serve as community-based consultants to other parents and families. Two family participation coordinators, themselves part of the PCN, function as leaders who work to assure family participation in all aspects

of program planning and policy development. They also provide family participation data, explore resources, participate in needs assessments, develop training materials, promote collaboration, and organize family advocacy efforts.

Families are playing a large role in system development activities. For example, there will be a faculty member of the 2005 statewide learning collaborative who will provide content and guidance to primary care providers seeking to improve the family-centeredness of their practices. With reference to the Iowa Medical Home Initiative, there are family advisors participating on the practice facilitation teams. They provide a family perspective for quality improvement efforts relevant to family interests and experiences.

Families of CYSHCN are able to use the IOWA COMPASS Toll-Free Hotline as a statewide information and referral database specializing in information for people with disabilities, their families, and other community members.

#### Infrastructure Building Services

In keeping with evolving public health roles and responsibilities, CHSC is increasingly involved with a variety of activities to improve service system quality and capacity. CHSC is a leader and participant in efforts to both improve program-specific operations and meet larger scale community and state needs. The CHSC Policy and Planning Unit is the organizational structure that guides and facilitates CHSC's infrastructure building activities. The fundamental core public health functions of assessment, policy development, and assurance have been strengthened in the programmatic and environmental awareness of leadership staff. Greater attention to core public health functions is facilitated through basic knowledge and skill building opportunities.

Examples of notable CHSC infrastructure building efforts include: evaluation of the IEPC direct clinical service; development of a new model to expand access to pediatric behavioral and mental health services; hypothesis generation and testing using "Iowa Child and Family Household Health Survey" data; implementation and evaluation of the Iowa Medical Home Initiative and Healthy and Ready to Work Project; and collaborative systems planning with stakeholders in the Early Childhood Comprehensive Systems Project (ECCS) and the Assuring Better Child Health and Development (ABCD II ) Project. CHSC also partners in the infrastructure building efforts of the Iowa Early ACCESS (Part C, IDEA) Program and the Governor's children's mental health system redesign effort.

Building a structure that provides nutrition services to CYSHCN is a current challenge. Iowans have minimal and inconsistent coverage of nutrition therapy services for chronic diseases and conditions under both private insurance plans and government health plans. CHSC recognizes this health care service gap and continues to work towards a regionalized system of nutrition services for children with chronic medical-nutritional needs. Challenges to closing this gap include: identification of nutrition problems, access to nutrition professionals, and payment options for families accessing Registered Dietitians' services.

A special infrastructure building effort is a partnership with the Iowa Department of Education to support CHSC's Regional Autism Services Program (RASP). RASP services emphasize training community-based autism resource teams on the needs of children with autism. Major training areas include behavior management strategies, social skill development, and vocational training. The program also facilitates autism screening by CHSC regional offices for children 3-13 years old. The RASP links with the Autism Society of Iowa.

CHSC is a partner in the Iowa Leadership Education in Neurodevelopmental and Related Disabilities (ILEND) Program. ILEND develops leaders to improve systems of care for CYSHCN through graduate education and post-graduate training. CHSC participates in ILEND didactic and experiential learning with a focus on Title V goals and priorities. CHSC staff provide seminars describing emerging issues and infrastructure building efforts specific to the CYSHCN population.

## C. ORGANIZATIONAL STRUCTURE

The Iowa legislature designated the Iowa Department of Public Health (IDPH), a cabinet level agency, as the administrator for Title V and maternal and child health (MCH) services. The legislature also directs IDPH to contract with Child Health Specialty Clinics (CHSC) based at the University of Iowa Department of Pediatrics, as the state's Title V services for children and youth with special health care needs (CYSCHN) program. Statutory authority identified in the Code of Iowa (Chapter 135, Iowa Administrative Code 641, Chapter 76) provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified in House File 737 of the 2000 Session of the Iowa General Assembly. Contracts between IDPH and CHSC outline the responsibilities of both agencies for fulfilling the mandate for maternal and child health services. Copies of the contracts are available upon request. Additional State of Iowa statutes relating to MCH and CYSCHN programs are listed in the attachment.

The IDPH Division of Health Promotion and Chronic Disease Prevention includes the Bureau of Family Health (BFH), the primary MCH unit within the state. Responsibility for the administration of the Title V Block Grant lies within the BFH. The tables of organization can be found at <http://www.idph.state.ia.us/to.asp>. The tables of organization illustrate the relationship of the division and the bureau within IDPH. The bureau also administers a portion of the state's Title X Family Planning services. The organizational structure of the Bureau of Family Health has remained stable in recent years, while IDPH itself has seen organizational change. Mary Mincer Hansen, R.N., Ph.D. was appointed as director of IDPH in March 2003. There are five divisions within the IDPH structure. They are the Division of Acute Disease Prevention and Emergency Response, the Division of Behavioral Health and Professional Licensure, the Division of Environmental Health, the Division of Health Promotion and Chronic Disease Prevention, and the Division of Tobacco Use, Prevention and Control.

Responsibility for coordinating Iowa's program for CYSCHN is administered by the IDPH Division of Health Promotion and Chronic Disease Prevention through a contract with the University of Iowa, Department of Pediatrics. Within the University of Iowa, Child Health Specialty Clinics (CHSC) has responsibility for administration of the contract. A table of organization for CHSC is located in the attachment.

### Bureau of Family Health

Public health functions relating to the health of mothers, children, and families are centered in the Bureau of Family Health (BFH). Organizational structures within BFH include the Women's Health Team and the Child Health Advocacy Team. Areas of work for these teams include system planning, standards of care development, contract management, and coordination of health-related services. Both teams collaborate with the Iowa Department of Human Services (DHS), the Iowa Department of Education (IDE), and the Iowa Regents Universities. The BFH contracts with local Child Health and Maternal Health agencies and health care providers to manage MCH programs at the local level. Listings of current contractors are located in the attachment. The BFH collaborates with the Oral Health Bureau (also a branch of the Division of Health Promotion and Chronic Disease Prevention, IDPH) to issue a joint Request for Proposal (RFP). The RFP is issued to community-based organizations interested in providing public health services for Child Health, Maternal Health, Family Planning, and Oral Health. The RFP requires contractors to link with The Bureau of Local Public Health Services, Bureau of Disease Prevention and Immunization, Early ACCESS (IDEA, Part C), Healthy Child Care Iowa, hawk-i (S-CHIP), and the Lead Poisoning Prevention Program. Selection is based on applicant ability to meet criteria in the areas of access, management, quality, coordination, and cost.

### Child Health Specialty Clinics

Responsibility for family-centered, community-based, coordinated care for children and youth with special health care needs (CYSCHN) is placed in the Child Health Specialty Clinics (CHSC) statewide system of regional child health centers. Since 1976, the regional centers have provided multidisciplinary community-based resources for children with complex health and health-related

problems. The regional centers support specialized diagnostic and evaluation services, care coordination services, family support, and infrastructure building efforts. The centers are staffed by nurse practitioners, nurse clinicians, parent consultants, and support staff. A map of the CHSC regional centers, in addition to other general program information, is located at [www.uihealthcare.com/chsc](http://www.uihealthcare.com/chsc).

#### Administration of Programs Funded by Block Grant Partnership Budget

IDPH is responsible for the administration of all programs carried out with allotments under Title V. Abstinence Education programs funded by Title V Section 510 and Community Based Abstinence Education (CBAE), formerly SPRANS, are coordinated within the Bureau of Family Health (BFH). A joint project coordinator is responsible for both abstinence education budgets and is assisted by two program planners. A project director housed in the BFH administers the State Systems Development Initiative (SSDI) funds awarded to Iowa. A nurse clinician functions as a liaison between the IDPH Bureau of Family Health and Information Management and serves as the SSDI project director. SSDI staffers work closely with the Genetics statewide coordinator who administers the grant from the MCHB Genetics Services Branch that also focuses on data integration. A project director and coordinator in the BFH administers Iowa's Early Childhood Comprehensive System project. A project coordinator in the BFH directs the administration of Iowa's Community Integrated Service Systems (CISS) grant that supports health and safety in early care and education programs. A community health consultant in the BFH serves as the coordinator for the Assuring Better Child Health and Development (ABCD II) grant from the National Academy of State Health Policy. As our State Medicaid Agency, DHS was the applicant and recipient of the grant.

CHSC manages several funded grants under the Iowa Medical Home Initiative (IMHI) that strive to assure that all Iowa CYSHCN are enrolled in a medical home. A three-year MCHB grant to CHSC facilitated the establishment of medical homes for CYSHCN in self-selected pediatric and family physician practices. A companion three-year MCHB grant to the Iowa Academy of Family Physicians (IAFP) supported a more local effort to establish medical homes for young children through enhanced primary practice and public health partnerships. These grants were consolidated with the goal of boosting medical home momentum in both the pediatric and family practice provider communities. Another MCHB-funded grant to CHSC to build a system of adolescent transition services promoted, among other system improvements, the medical home model for adolescents with special health care needs. A contract between CHSC and Iowa's Part C Program has provided significant professional development funds to support the IMHI effort.

As these three grants near termination, a new MCHB grant to build integrated systems for CYSHCN will extend federal support for system improvement. This will occur through linking primary care practices to Title V care coordination resources, offering learning collaboratives to stimulate practice-based quality improvement efforts, and enhancing partnerships to increase early and continuous screening in primary care settings. Part C, through renewal of the professional development contract, is continuing to support this system improvement effort.

Iowa's Early Hearing Detection and Intervention (EHDI) Program is a collaborative effort. Child Health Specialty Clinics administers a HRSA MCH Improvement Projects Grant to improve the system of newborn hearing screening and follow-up in Iowa. In addition, the Iowa Department of Public Health is developing a surveillance and monitoring system through a cooperative agreement with the Centers for Disease Control and Prevention. In January 2004, a bill was passed by the legislature, and signed by the governor, that mandates newborn hearing screening in Iowa. The bill requires that all newborns be screened for hearing loss prior to discharge from hospital and that the results be reported to IDPH. The program director, within the BFH, has been providing technical assistance to maternity hospitals to begin data input into the EHDI data system.

Early ACCESS is Iowa's program funded by the Individuals with Disabilities Education Act (IDEA, Part C). Early ACCESS is an interagency collaboration between the Iowa Department of Education, the Iowa Department of Public Health, the Iowa Department of Human Services, and Child Health Specialty Clinics. The system is a partnership between families with young children, birth to age three,

and providers from local public health, human service, education, and child health specialty agencies. The Iowa Department of Education is the lead agency, as appointed by the Governor of Iowa for the implementation and maintenance of the system.

The IDPH Bureau of Family Health, in collaboration with the Community Empowerment branch of the Iowa Department of Management, applied for a HRSA State Maternal and Child Health Early Childhood Comprehensive Systems Implementation Grant in May 2005. Iowa developed an Early Care, Health, and Education Strategic Plan and will be using the three year implementation grant to help carry out strategies. A project director in the BFH directs the coordination of the Early Childhood Comprehensive System Grant (ECCS). The grant is coordinated through the IDPH and the State Empowerment Technical Assistance Team.

#### ABCD II - Assuring Better Child Health and Development

In November 2003, the National Academy for State Health Policy (NASHP) approved the Iowa Department of Human Services' grant application for the Assuring Better Child Health and Development (ABCD) initiative. Funded by the Commonwealth Foundation, this grant project is aimed at identifying and implementing policy and system changes to support the provision of preventive care by Medicaid providers to children 0 to 3. The NASHP funding of \$55,000 per year is matched by Medicaid funding of the same amount. Iowa intends to move toward the development and infusion of healthy mental development services into our current EPSDT system.

### **D. OTHER MCH CAPACITY**

#### Maternal and Child Health

The administrative office for Iowa's Title V program is located in the capitol complex in close proximity to the State Capitol, in Des Moines, Iowa. The IDPH employs the Bureau of Family Health Chief, a Division Medical Director, and 22 professional and four support staff who manage the functions of Iowa's Title V program. Dr. Jeff Lobas, director of Child Health Specialty Clinics, serves as the medical director for the Division of Chronic Disease and Health Promotion for 20 percent. The department contracts with 25 local maternal health agencies and 25 local child health agencies to provide local MCH services throughout the state. For additional information about the responsibilities and structure of the local contract agencies see section 3B Agency Capacity.

Bureau of Family Health (BFH) staff members provide the capacity for policy development, program planning, and evaluation functions. Data reporting and analysis functions are provided through the capabilities of staff in the IDPH Bureau of Information Management (BIM) and the IDPH Center for Health Statistics (CHS). A BIM staff member serves as liaison to the BFH and focuses on data integration efforts for the major MCH data systems in Iowa. A CHS senior statistician coordinates all analysis requirements for Title V programs.

The Bureau of Family Health and the Center for Health Statistics have established an agreement with CDC to have an MCH epidemiologist assigned to Iowa. Dr. Debbie Kane will assist the Department by providing consultation, technical assistance, surveillance, and analysis of epidemiological information for Iowa's MCH population. Initial activities have focused on Needs Assessment and data integration and data linkages.

#### CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Iowa's Title V Program for CYSHCN, Child Health Specialty Clinics (CHSC), is an administrative responsibility of the Iowa Department of Public Health, Division of Health Promotion and Chronic Disease Prevention, managed through a contract with the University of Iowa, Department of Pediatrics. CHSC maintains an Iowa City administrative office, as well as 12 regional centers located in or near the state's population centers. Most Iowans are within a one-hour drive of a regional center.

Of the total staff complement, 24 individuals are housed in the Iowa City office. The remaining 66 staff members are housed in or associated with the other 12 CHSC regional centers.

The capacity to perform core public health functions is shared among professional and support staff. Policy and Planning Unit staff have education and experience in public health science and practice and take a lead role in coordinating core public health activities. Families of CYSHCN add program capacity through the Parent Consultant Network (PCN), a community-based network of part-time parent consultants affiliated with the regional centers. The current roster of the PCN is attached. CHSC's family participation program is led by two experienced members of the PCN. They lead the PCN by advising on policy and program planning, recommending training, monitoring activity, and updating resource information. All parent consultants undergo a structured training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports.

External contracts and grants have increased CHSC's capacity to contribute to prescribed priorities. Contracts with the Iowa Department of Education Part C Program expand CHSC's participation in the areas of early intervention (especially system development and quality assurance) and medical home training (especially the early childhood screening component). A contract with the Iowa Department of Human Services commits CHSC to provide care coordination to "medically fragile" children enrolled in Medicaid Waiver Programs. A contract with Magellan Behavioral Health Corporation supports CHSC's leadership in improving statewide access to pediatric mental and behavioral health services. Finally, an MCHB grant supports a systems integration effort that highlights medical home model spread, linkage of primary care providers with public health care coordinators, and partnerships to improve early childhood screening and referral practices.

Another significant element of program capacity relates to service billing. CHSC professional services are systematically billed at levels that accurately reflect the intensity and skill of the service. A sliding fee scale continues to be employed to determine family liability.

Senior level management employees are M. Jane Borst, chief of the IDPH Bureau of Family Health and Dr. Jeffrey Lobas, director of Child Health Specialty Clinics. Their qualifications appear in brief biographies attached to this section.

## **E. STATE AGENCY COORDINATION**

The following descriptions highlight significant organizational relationships within Iowa that enhance the capacity of the Title V program. These descriptions do not capture extensive coordination efforts undertaken by the state's Title V program. A complete listing of formal and informal organizational relationships is located in the attachment.

### **Special Supplementary Nutrition Program for WIC**

The statewide WIC program is integrated with MCH services at the state and local levels. The Bureau of Nutrition and Health Promotion coordinates the nutrition components of MCH projects and provides staff assistance to both state and local MCH programs. Training, consultation, and educational programs are provided for all MCH programs. The Iowa Lactation Task Force, a statewide coalition, includes private sector and public health professionals who provide technical assistance to the WIC program, MCH, family planning, public health nursing/visiting nurse agencies, and private health care providers.

### **Family Planning**

The Iowa Department of Public Health (IDPH) provides family planning services in 45 of the 99 counties in Iowa through Title X funding. A map showing the location of family planning services in Iowa can be viewed at [http://www.idph.state.ia.us/hpcdp/pdf/fp\\_map.pdf](http://www.idph.state.ia.us/hpcdp/pdf/fp_map.pdf). A program coordinator, housed in the IDPH Bureau of Family Health, manages services provided by eight contracted

agencies. IDPH Family Planning Service Area (IDPHFPSA) contains four metropolitan counties and two urban counties. The balance of the IDPHFPSA contains rural counties. The Iowa counties not part of the IDPHFPSA, are funded with Title X dollars through the Family Planning Council of Iowa.

#### DHS Cooperative Agreement

IDPH's Division of Health Promotion and Chronic Disease Prevention maintains an ongoing cooperative agreement with the Department of Human Services. The agreement defines cooperative efforts toward an integrated system of high quality, comprehensive, cost-effective, adequately financed health services for mutual beneficiaries. The annual agreement is available upon request.

#### EPSDT Care for Kids.

The Iowa Department of Public Health (IDPH) provides services for the EPSDT Care for Kids program under an intergovernmental agreement with the Iowa Department of Human Services (DHS). Under this agreement, local child health contract agencies are approved as EPSDT screening centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the child's Medicaid coverage and the importance of well-child care. Care coordinators also contact the family when the child is due for well-child care according to the EPSDT Periodicity Schedule. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical and dental care. Care coordinators partner with local physicians to ensure children receive the comprehensive screening requirements of the program. BFH staff members routinely provide training and technical assistance to local EPSDT care coordinators. Topics include developing care coordination skills, determining the costs for informing and care coordination activities, and maintaining the electronic clinical record.

State agency coordination is necessary throughout the EPSDT Care for Kids program in order to assure that families receive appropriate services. Data system integration between the two state departments occurs every day in order to give local child health agencies access to current Medicaid eligibility information. To accomplish this level of integration, the Iowa Title XIX database, at DHS, sends eligibility information to the Child and Adolescent Reporting System (CAREs), at IDPH, every day at midnight. The next day local child health agencies can obtain Medicaid eligibility information for a child directly from CAREs. As services are provided to the child, clinical record documentation is entered in CAREs by the local agency staff.

The Bureau of Family Health coordinates with related IDPH programs in managing the EPSDT Care for Kids program. Ongoing and routine communication occurs with program staff involved in immunizations, lead poisoning prevention, early intervention services, oral health, behavioral health, and other programs related to the health of Iowa's children.

#### hawk-i (Health and Well Kids in Iowa)

In October 2002, the Department of Human Services (DHS) contracted with IDPH to provide grassroots outreach and enrollment for hawk-i. In November 2002, IDPH contracted with the 25 local child health agencies to perform hawk-i outreach and enrollment efforts. Collaboration between IDPH and DHS will continue to guide successful outreach to uninsured families in Iowa. Outreach efforts focus on four areas: schools, health care providers, faith-based organizations, and special populations. Additional efforts have included businesses, workforce development, chambers of commerce, insurance agents, and tax preparation sites. Efforts will be expanded over the next year to continue coordination of state level outreach efforts through an Outreach Task Force and further development of partnerships, such as working with community and migrant health centers, free clinics, school nurses, ministers, and other community representatives.

#### Preventable Diseases Program

The Disease Prevention and Immunization Bureau administers the program for vaccine preventable diseases. Vaccines are available to local health departments, child health agencies, and private physician's offices for required childhood immunizations. The Immunization Registry Information System (IRIS), a web-based registry, now serves the state's public sector clinics and private providers. The Bureau of Family Health, the Disease Prevention and Immunization Bureau, and

Department of Human Services collaborate to promote statewide utilization of the registry in both public and private clinics.

#### Childhood Lead Poisoning Prevention Program

Since nearly 40 percent of the state's housing was built prior to 1950, IDPH recommends that all Iowa children under the age of six receive routine blood lead testing. Local contract agencies, local health departments, and private practitioners test children. Through continuing education programs, IDPH educates private practitioners about the importance of testing children for lead poisoning. Case management of children with lead poisoning is a collaborative effort of the Childhood Lead Poisoning Prevention Program, the Bureau of Family Health, local contract agencies, and local health departments.

#### Bureau of Local Public Health Services

The Bureau of Local Public Health Services was established to strengthen the public health delivery system in Iowa at both the state and local level. This is achieved through strengthening the capacity of Iowa's local boards of health who, through local health departments, public health agencies, programs and services, strive to create healthy people in Iowa communities.

The bureau will promote and support development of public health infrastructure at the local and state level to assure that Iowa's public health system has the capacity to be responsive to current and emerging public health issues.

#### Iowa Center for Congenital and Inherited Disorders

The Center for Congenital and Inherited Disorders (CCID), in partnership with the University of Iowa and health care providers throughout the state, provides comprehensive genetics services. IDPH manages the five CCID programs with assistance from the Congenital and Inherited Disorders Advisory Committee (CIDAC). The five programs are the Iowa Neonatal Metabolic Screening Program (INMSP), the Expanded Maternal Serum Alpha-fetoprotein Screening Program (MSAFP), Regional Genetic Consultation Services (RGCS), the Neuromuscular and Related Disorders Program, and the Iowa Registry for Congenital and Inherited Disorders (IRCID). See National Performance Measure #1 for additional information about the INMSP. The INMSP, the RGCS, and the Neuromuscular and Related Genetic Disorders Program conduct statewide outreach clinics. Clinics offer diagnostic evaluation, confirmatory testing, medical management, education, case management, consultation, and referral.

The IRCID mission is to maintain statewide surveillance for collecting information on birth defect occurrence in Iowa, monitor annual trends in birth defect occurrence and mortality, conduct research studies to identify genetic and environmental risk factors for birth defects, and promote educational activities for the prevention of birth defects. In 2002, the IBDR developed a parental notification system that informs parents or guardians of children who are diagnosed with a birth defect and provide them with resource information. The parental notification system includes a resource brochure, and a notification letter. The IRCID works to develop mechanisms to enhance IDPH access and utilization of birth defects surveillance data. IDPH is also working with the various early intervention programs including IDEA, Part C (Early ACCESS), Title V, IDPH Child Health Advocacy Team, and parent groups to ensure that IRCID data are made available for them to use for program planning. The CCID works closely with the Early Hearing Detection Initiative to coordinate screenings for all newborns in the state.

Matching of newborn metabolic screening and birth certificate records is performed to identify unscreened newborns. Follow-up is made with the birthing facility and/or physician's office to arrange for screening of missed newborns. The INMSP and IBDR collaborate with the Child Death Review Team to decrease unnecessary contact of families whose child has died. Newborn screening education to nursery managers, lab managers, and health care providers is provided through the quarterly "Heel Stick News" and the "INMSP Healthcare Practitioner's Manual" found on the web site. [www.idph.state.ia.us/genetics](http://www.idph.state.ia.us/genetics)

The IRCID will begin conducting surveillance on stillbirths starting in October 2005. Birthing facilities will receive education from the Statewide Perinatal Care Team on the use of a stillbirth evaluation tool. Providers will complete the information required in the tool, and submit it to the IRCID.

#### Unintentional Injury Prevention

The Bureau of Family Health collaborates with multiple partners to prevent unintentional injuries to children. Staff from the BFH represent maternal and child health on the Iowa Safe Kids Coalition as well as the Greater Des Moines Safe Kids Coalition. Through the Healthy Child Care Iowa campaign, state agencies collaborate regarding health and safety in child care. Distance learning opportunities are offered quarterly to consultants who work with early care and education. Consultants with the following statewide programs are invited to participate in continuing education opportunities:

- Iowa Department of Education's Head Start/Early Head Start program
- Iowa Department of Education's Shared Visions preschool program
- Iowa Department of Education's Child and Adult Care Food Program
- Iowa Department of Human Services' Child Care Unit
- Iowa Department of Management's Office of Community Empowerment
- Iowa Department of Public Health's Bureau of Emergency Medical Services
- Iowa State University Extension's family life specialists

The Bureau has developed partnerships with entities regarding chemical exposures of children in early care and education programs. The BFH collaborates with the Division of Environmental Health, Environmental Protection Agency, Iowa Department of Agriculture and Land Stewardship, Iowa Department of Education, Iowa Department of Human Services' Child Care Unit, Iowa State University's Department of Entomology, Iowa State University Department of Human Development and Family Studies, and Iowa State University Extension.

The Bureau of Family Health works closely with the Governor's Traffic Safety Bureau (GTSB) to identify strategies for information dissemination. Local maternal and child health agencies are able to request free educational materials from the GTSB to share with clients at their local agencies, particularly regarding child passenger safety.

The BFH collaborates with the Division of Environmental Health's liaison to the U.S. Consumer Product Safety Commission. The U.S. Consumer Product Safety Commission has funded an injury prevention pilot project in northwest Iowa in child care for more than two years. Child Care Nurse Consultants visit child care and early education providers onsite using a Consumer Product Safety Commission-approved checklist to assess hazardous and recalled children's products. The Injury Prevention Checklist will be rolled out statewide for use by child care nurse consultants at the statewide Early Care, Health, and Education Congress in November 2005.

#### Early ACCESS

Early ACCESS is a federal program under the Individuals with Disabilities Education Act (IDEA, Part C). In Iowa, the program is an interagency collaboration between the Iowa Department of Education, the Iowa Department of Public Health, the Iowa Department of Human Services, and CHSC. The system is a partnership between families with young children, birth to age three, and providers from local public health, human service, education, and child health specialty agencies. Partnerships also exist for families with other public or private service and resource providers. The Iowa Department of Education is the lead agency, as appointed by the Governor of Iowa, for the implementation and maintenance of the system. A state level multidisciplinary council, the Iowa Council for Early ACCESS, advises and assists the Iowa Department of Education in the implementation of the Early ACCESS system.

#### Federally Qualified Health Centers

Iowa currently has eight designated Federally Qualified Health Centers (FQHC) in Council Bluffs, Davenport, Des Moines, Ottumwa, Sioux City, Waterloo, Burlington and Decatur County. Storm Lake and Fort Dodge will receive New Start Funds in December 2005, with operations to begin in April

2006. Two of the six designated centers have subcontracts with IDPH for community-based child health centers. The remaining six FQHCs collaborate with the designated local MCH contract agencies in their area.

#### Primary Care Association

The Iowa Department of Public Health has a long-standing relationship with the Iowa/Nebraska Primary Care Organization (IA/NEPCA). The association provides technical and non-financial assistance to the community and migrant health centers of Iowa and Nebraska. These health centers offer comprehensive, physician-based "one-stop" primary care with a focus on prevention. The seven community health centers in Iowa are IA/NEPCA members. The association works closely with the state departments of health in Iowa and Nebraska, along with the Federal Bureau of Primary Health Care, and participates in collaborative activities promoting quality health care services.

#### College of Public Health, The University of Iowa

Founded in 1999, the College of Public Health strives to be a comprehensive public health resource for the state of Iowa. The college consists of six departmental units: Biostatistics, Community and Behavioral Health, Epidemiology, Health Management and Policy, Occupational and Environmental Health, and the Program in Public Health Genetics. Degree programs include the MPH, MS, MHA, and Ph.D. A Public Health Certificate Program was initiated in 2002. Iowa's only fully accredited school of public health, the college is also home to 28 centers and institutes that conduct research and provide public service throughout the state, the nation, and the world.

#### Des Moines University

The Master of Public Health program at Des Moines University (DMU) began in 1999 and received full accreditation from the Council on Education for Public Health in 2002. The MPH program is offered at a number of sites around the state. A dual degree program offers students the opportunity to obtain both the MPH and MPA. A Graduate Certificate in Public Health is also offered. DMU is developing courses for web-based delivery to accommodate the needs of Iowa's rural public health work force.

#### Child Health Specialty Clinics

The Child Health Specialty Clinics (CHSC) administrative offices are located at the University of Iowa in Iowa City. Proximity to a major university health center provides a source of pediatric and public health expertise that is shared with CHSC's statewide staff and collaborating agencies. Continuing education programming occurs on-site in Iowa City, at community locations, over the statewide fiberoptic communication network, and via Internet webcam connections. Health professions and public health students--graduate and undergraduate--learn about community-based service delivery through participation in direct care specialty clinics, care coordination services, and infrastructure building activities. CHSC's relationship with the University provides information technology resources, financial management services, public policy expertise, and research design and program evaluation consultation.

CHSC maintains interagency agreements with state entities. The following list indicates the agencies with which CHSC maintains agreements and summarizes the purpose of each agreement.

1. The IDPH Bureau of Family Health--to promote development of a cooperative and collaborative relationship at state and local levels through cross-referrals, sharing of staff, coordinating staff training, and interfacing data systems.
2. The Iowa Department of Education, Division of Vocational Rehabilitation, Disability Determination Services Bureau--to define responsibilities related to applicants and recipients under age 16 of the Supplemental Security Income Program (SSI) and under age 22 who need specialized health services regardless of SSI eligibility.
3. The Iowa Department of Human Services--to define responsibilities of the parties in assessment, planning, and care coordination activities for recipients of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) of the Iowa Medical Assistance Program (Title XIX).
4. The Iowa Department of Human Services--to define responsibilities of the parties in assessment, planning, and care coordination activities for applicants and recipients of the consolidated Waiver

Programs of the Iowa Medical Assistance Program (Title XIX).

5. The Iowa Departments of Public Health, Education, and Human Services and the Office of the Lieutenant Governor--to delineate the roles and responsibilities of each of the parties related to the implementation of the provisions of Part C of IDEA, including principles of family involvement, coordination of resources, and nonduplication of services.

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

The nine Health System Capacity Indicators (HSCI) provide critical information about the capacity of Iowa's MCH systems and programs to serve the Title V populations. Iowa made progress on the HSCI in recent years, as indicated on forms 17-19. There are several reasons for the improvements seen in the HSCI measures.

State agency coordination activities, such as those described in the previous section of this application, have had a positive impact on the capacity of IDPH to progress on specific initiatives. For example, the child health program and the oral health program have worked together to increase access to oral health services for children throughout the state. Ongoing partnerships between IDPH and other state departments have also had a positive impact.

MCHB State Systems Development Initiative (SSDI) grants have also had a positive influence on the capacity of Iowa's MCH systems and programs. The FFY02-FFY03 SSDI grant sparked the formation of the Data Integration Steering Committee, composed of mid-level managers, and the MCH Data Integration Team, composed of database managers. The two organizational structures provided a routine mechanism for strengthening the knowledge base and communication of key members of Iowa's MCH data workforce. Iowa's FFY04-FFY06 SSDI grant, called the Iowa MCH Data Capacity Project, provided funding for the two data integration structures to continue. In addition, the current SSDI grant provided important seed money for the 2005 replication of the Iowa Child and Family Household Health Survey, described in form 19 - HSI 9C. Multiple MCH-related programs contributed additional funding to allow the survey to be repeated five years after it was first conducted. The resulting population-based trend data will increase the state's capacity to assess the health of children throughout Iowa.

Iowa's capacity to obtain, analyze, and utilize health data has been improved through the aggressive pursuit of discretionary grant funding. The following descriptions, specific to the individual HSCIs, provide information about the positive impact of associated discretionary grants.

### **Health Systems Capacity Indicator #01**

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 - 493.9) per 10,000 children less than five years of age.

In Iowa, about seven percent of the population has asthma. Asthma causes 50 to 60 deaths, 12,000 inpatient hospitalizations, and 40,000 to 50,000 emergency department visits each year. The direct medical and indirect economic cost associated with asthma in Iowa each year is estimated at \$150,000,000.

Healthy People 2010, identifies respiratory diseases (asthma, COPD, and sleep apnea) as one of 28 priority areas for public health intervention and includes an objective to establish asthma surveillance systems in at least 25 states by the year 2010. Healthy Iowans 2010, Iowa's plan for improving the health of Iowans, includes asthma among 23 priority public health issues for the next 10 years.

The Iowa Plan for Improving the Health of Iowans with Asthma was adopted by the Iowa Asthma Task Force and the Iowa Department of Public Health (IDPH) in the spring of 2003. The plan calls for surveillance of both health outcomes related to asthma (asthma prevalence, deaths, hospitalizations) and of risk factors for developing asthma (exposure to tobacco smoke, allergens).

The report for HSCI #01 appears on Form 17.

#### Health Systems Capacity Indicator #02

The percent of the state's Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening.

As discussed in the Overview of the State section of this application, IDPH provides services for the EPSDT Care for Kids program under an intergovernmental agreement with the Iowa Department of Human Services (DHS). Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the child's Medicaid coverage and the importance of well-child care. Care coordinators also contact the family when the child is due for well-child care according to the EPSDT Periodicity Schedule.

State agency coordination is necessary throughout the EPSDT Care for Kids program in order to assure that families receive appropriate services. Data system integration between the two state departments occurs every day in order to give local child health agencies access to current Medicaid eligibility information. To accomplish this level of integration the Iowa Title XIX database, at DHS, sends eligibility information to the Child and Adolescent Reporting System (CAREs), at IDPH, every night. The next day, local child health agencies can obtain Medicaid eligibility information for a child directly from CAREs. As services are provided to the child, clinical record documentation is entered in CAREs by the local agency staff.

The report for HSCI #02 appears on Form 17.

#### Health Systems Capacity Indicator #03

The percent of the state's Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

Iowa's SCHIP program, called Healthy and Well Kids in Iowa (hawk-i), is housed in the Iowa Department of Human Services (DHS). DHS contracts with the Iowa Department of Public Health for statewide hawk-i outreach activities. To fulfill its responsibilities, IDPH employs a statewide hawk-i outreach coordinator and contracts with local child health agencies for community outreach activities.

The report for HSCI #03 appears on Form 17.

#### Health Systems Capacity Indicator #04

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

A MCHB discretionary grant has allowed IDPH to implement the Assuring Women's Access to Health Resources (AWARe) project. This project strives to raise awareness of women's health issues across the lifespan through efforts in three areas:

- 1) IDPH level infrastructure to assure coordination of women's health programs and services,
  - 2) women's access to accurate, understandable, and culturally competent health information, and
  - 3) best practices for influencing women's health behaviors through improving women's health literacy.
- Implementing this proposal will benefit women across their lifespan and their families.

Iowa's capacity for data collection related to HSCI #04 is enhanced by the statewide use of the Women's Health Information System (WHIS). All local contract agencies in the state use the centralized WHIS to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. This information assists the state in determining adequacy of care according to the Kotelchuck Index.

The report for HSCI #04 appears on Form 17.

#### Health Systems Capacity Indicator #05

The comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

Iowa's SSDI grant, called the Iowa MCH Data Capacity Project, is described in the introduction to this section of the application. A specific SSDI objective calls for Iowa to demonstrate improvement in the data linkages between birth records and infant death certificates, Medicaid eligibility files, Medicaid paid claims files, WIC eligibility files, and newborn screening files. Iowa's capacity to move forward on this SSDI objective improved with the assignment of an MCH epidemiologist from the Centers of Disease Control and Prevention in 2005. The assignee's responsibilities have been carefully determined to coincide with Title V needs and SSDI objectives

The report for HSCI #05 appears on Form 18.

#### Health Systems Capacity Indicator #06

The percent of poverty level for eligibility in the state's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

There are two MCH epidemiologists in the IDPH Center for Health Statistics. One is the CDC assignee described above and the other is a fulltime staff member. The Center for Health Statistics assists IDPH program staff in calculations of percent of poverty levels for eligibility for both Medicaid and SCHIP.

The report on HSCI #06 appears on Form 18.

#### Health Systems Capacity Indicator #07

The percent of the state's EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

In Iowa, the percentage of EPSDT eligible children who received dental services has climbed steadily over the last five years from 42% in FFY00 to 51.9% in FFY04. According to the CMS-416 Annual EPSDT Participation Report, there were 43,717 children in Iowa aged 6 through 9 years who were eligible for EPSDT in FFY04. Of those children, 22,678 received dental preventive and/or treatment services through the EPSDT program.

The Oral Health Bureau (OHB) obtained a HRSA State Oral Health Collaborative Systems (SOHCS) grant. This discretionary grant funding will allow the OHB to assess the oral health needs and assets in Iowa communities. Project activities will focus on the development of public and private partnerships to leverage and align resources to improve the state's oral health.

The report on HSCI #07 appears on Form 17.

#### Health Systems Capacity Indicator #08

The percent of the state's SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

Under Title V legislation, the state CYSHCN Program has responsibility to provide rehabilitation services to children, 0-16 years old, enrolled in Title XVI (SSI) to the extent that medical assistance is not provided by Medicaid. Child Health Specialty Clinics (CHSC) addresses this requirement by sending a detailed letter to all children approved for the SSI Program by the Social Security Administration, except for those cared for in hospitals or DHS-funded foster care homes. The letter reminds parents to apply for the Medicaid benefits to which they are entitled as SSI enrollees in Iowa. The letter further reminds parents to inquire about other Department of Human Services Programs - Health Insurance Premium Payment; EPSDT; and Home and Community-Based Services Waivers. Finally, for interested families, a brochure for the statewide toll-free referral service for Iowans with disabilities (Iowa COMPASS) is shared along with other brochures and telephone numbers for CHSC.

The report on HSCI #08 appears on Form 17.

#### Health Systems Capacity Indicator #09(A)

The ability of the state to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant data.

State Performance Measure #8 links with this HSCI by evaluating the degree to which key data are collected, managed, analyzed, and utilized for strategic assessment of the determinants and consequences of the health status of women, children, and families. A complete description of data capacity building accomplishments related to SPM #8 and HSCI #09(A) can be found in the SPM #8 narrative.

The report on HSCI #09(A) appears on Form 19.

#### Health Systems Capacity Indicator #09(B)

The ability of the state to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

The IDPH tobacco program focuses on four goals:

- 1) preventing the initiation of tobacco use among young people,
- 2) promoting cessation among young people and adults,
- 3) eliminating nonsmokers' exposure to secondhand smoke, and
- 4) identifying and eliminating disparities related to tobacco use and its effects among different population groups.

Just Eliminate Lies (JEL) is a youth-led movement targeting tobacco use throughout Iowa. JEL youth members work with their local partnerships to establish youth coalitions, recruit and educate new members, and coordinate events such as the Unfiltered JEL Summit, scheduled for July 25-27, 2005, at Iowa State University. Quitline Iowa is a toll-free smoking cessation helpline that provides information, materials, and follow-up. Trained counselors provide services seven days a week in English and Spanish.

The report on HSCI #09(B) appears on Form 19.

#### Health Systems Capacity Indicator #09(C)

The ability of the state to determine the percent of children who are obese or overweight.

In 2004, IDPH obtained funding through a five-year CDC cooperative agreement called Nutrition and Physical Activity to Prevent Obesity and Other Chronic Diseases. The new funding allowed the IDPH Bureau of Nutrition to target obesity-related issues beyond food intake. The project, named "Iowans Fit for Life," focused on nutrition and physical activity to prevent obesity and other chronic diseases.

Iowa's capacity for data collection and analysis related to obesity will receive a boost when the 2005 Iowa Child and Family Household Health Survey is conducted. The population-based survey will contain a carefully designed section of questions on nutrition and physical activity.

The report on HSCI #09(C) appears on Form 19.



## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

The annual plan for FFY06 places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a rural state with substantial shortages of medical services and maldistribution of existing services, Iowa is challenged to develop systematic approaches to population based direct care services. In the past few years, program activities addressed improvement of access to services, identification of the needs of culturally diverse groups, and recognition of changes brought about by managed care. Additionally activities for children and youth with special health care needs focused on assuring specialty services to children and families, integrating data systems, balancing private and public partnerships, and integrating community based services.

### **B. STATE PRIORITIES**

#### **DIRECT HEALTH CARE AND ENABLING SERVICES:**

1. Need Statement: Assure access to pediatric specialty care for all children.

Analysis of the "2000 Iowa Child and Family Household Health Survey" provided information about the health status and related circumstances of families, both those with and without CYSHCN. Twenty-five percent of families with a CYSHCN had trouble getting specialty care when their child needed it. In contrast, 11 percent of families without a CYSHCN also had trouble accessing specialty care when needed. In the Title V needs assessment prioritization process, stakeholders ranked increased access to pediatric specialty care for all children as the #12 priority need.

2. Need Statement: Minimize developmental delay through early intervention services for children 0-3 years.

According to a report from the U.S. Department of Education, Office of Special Education Programs, Iowa's Early ACCESS system served 1.11 percent of Iowa's 0-1 year old children and 2.07 percent of Iowa's 0-3 year old children in 2004. Thus, Iowa met the OSEP recommendation that early intervention programs serve 1 percent of children 0-1 and 2 percent of children 0-3. In the Title V needs assessment prioritization process, increased access to early intervention services was ranked as the #3 priority need by stakeholders.

3. Need Statement: Assure developmental evaluations are provided to Medicaid enrolled children 0-3 years.

In Iowa, approximately 18,000 children ages 0-3 years need mental health services each year. This means that one in five young Iowans experience the signs and symptoms of mental disorders. According to a Commonwealth Report, "12 to 16 percent of children experience developmental problems, only one-third of those children usually those with the most obvious conditions- are identified in pediatric practices prior to school entry." In the Title V needs assessment prioritization process, increased developmental evaluations for children 0-3 years was ranked as the #11 priority need by stakeholders.

According to data from the "2000 Iowa Child and Family Household Health Survey," thirty percent of families with CYSHCN and four percent of families without CYSHCN required behavioral or emotional care in the previous year. A review of the "Community Health Needs Assessment and Health Improvement Plan" indicates that 14 counties are addressing mental health issues. Examples of priority issues for these counties are: poor access to services and health professionals, limited number of rural psychiatrists for adults and children, and inadequate mental health screening.

4. Need Statement: Improve the quality of family support and parenting education programs and services.

Iowa currently does not have an integrated, comprehensive systemic approach to family support, home visitation, and parenting education. Most of Iowa's local home visiting programs and parenting education programs follow the model that meets the funding requirements. At the local level, Community Empowerment Areas are statutorily required to strive for spending 60 percent of their state funds on family support, home visiting, or parenting education. Community Empowerment Areas use a variety of national models and community-created models. Currently, Iowa supports the HOPES-HFA (Healthy Opportunities for Parenting to Experience Success -- Healthy Families America) model through IDPH. Twelve counties use this home visiting model. Additional counties use a HOPES-like model for their home visiting program. Counties use the HOPES-like model because of the cost and lengthy accreditation process required by "official" HOPES-HFA Program. There are also 64 Parents as Teachers (PAT) programs throughout the state. The locally designed models generally do not include an evaluation component or preventive health component, both of which are included in more widespread evidenced-based models. In the Title V needs assessment prioritization process, improve the quality of family support and parenting education programs and services was ranked as the #9 priority need by stakeholders.

In the Community Health Needs Assessment and Health Improvement Plan, three counties are addressing parenting and family support issues. These counties will focus on unifying and improving availability of parenting education classes in their communities.

#### POPULATION-BASED SERVICES:

5. Need Statement: Improve the quality of primary care for children in Iowa.

Iowa's screening plan for preventive health services for children is consistent with standards established by the American Academy of Pediatrics. The periodicity schedule for comprehensive health screening for all children ages 12 months to 6 years includes testing for blood lead levels. Quality improvement reviews of preventive care records for Medicaid eligible children suggest that lead screening is likely to be the last component of the comprehensive screen to be completed. For this segment of the child health population, it appears that there is a correlation between the completeness of the recommended preventive health screen and testing for lead poisoning. Based on this observation, Iowa selected blood lead testing as an indicator of the comprehensiveness of primary care provided to children. The measure of children receiving a blood lead test is identified as a proxy measure for the quality of primary care provide for children.

In 2000, the Iowa Department of Public Health started to examine elevated blood lead rates for birth cohorts. A birth cohort represents children who were all born in a given time period. The percentage of children tested and the prevalence of lead poisoning were determined for children under the age of six years. Data analysis for the 1998 birth cohort was complete as of December 31, 2004. Of 37,262 children born in 1998, 57.1 percent received a blood lead test before the age of six years. Of children who were tested, 7.5 percent had blood lead levels greater than 10 micrograms per deciliter ( $\mu\text{g/dL}$ ), which is the blood lead level used to define lead poisoning. This is more than three times the national average of 2.2 percent. The Medicaid population is of special concern because the prevalence of lead poisoning in Medicaid children is 2.5 times the prevalence of lead poisoning in non-Medicaid children. In the Title V needs assessment prioritization process, stakeholders ranked improve the quality of primary care for children in Iowa as the #5 priority need.

The Community Health Needs Assessment and Health Improvement Plan from local boards of health indicated that 17 counties are addressing lead screening and follow-up. Most of the counties will focus on educating health care professionals and parents on the importance of lead screening for children under six years old.

6. Need Statement: Assure access to oral health care for children in Iowa.

Access to dental care for low-income families in Iowa is limited due to a number of barriers. These include: lack of financial resources to pay for care, lack of knowledge of the importance of good oral health, lack of dentists willing to see children under the age of three, shortage of dentists participating

in the Medicaid program, shortage of dentists within the state, and issues of patient compliance.

In the "2000 Iowa Child and Family Household Health Survey," eight percent of responding families reported there was a time during the previous year that their child needed dental care, but could not obtain it. In the Title V needs assessment prioritization process, increased access to oral health services was ranked as the #6 priority need by stakeholders.

In the Community Health Needs Assessment and Health Improvement Plan, four communities are focusing on access to dental services for children, including Medicaid clients. Most of these communities will work with their local MCH agency to help with recruitment of dentists to treat all children at an earlier age.

7. Need Statement: Assure children enrolled in early care and education programs are in quality environments.

Iowa ranks in the top three states for percentage of children under age six whose parents are in the labor force. Seventy-seven percent of Iowa families with children 0-5 years old have both or the only parent working. The increase of working parents in the last decade has resulted in the need for child care arrangements for about 30,000 additional children. In the Title V needs assessment prioritization process, stakeholders ranked improve health and safety in child care and preschool as the #10 priority need.

According to the "2000 Iowa Child and Family Household Health Survey," almost half (46%) of Iowa children under age 10 receive child care from someone other than a parent. Four percent of parents of CYSHCN were very dissatisfied with their child care arrangements compared to only one percent of parents of other children. The parents of CYSHCN were more likely than parents of other children to report trouble finding child care when their child was sick (33% vs. 25%). About one-third of parents of CYSHCN had difficulty finding child care because of the child's special health care need.

The Midwest Research Consortium on Quality in Child Care documented the status of quality on Iowa's early care and education programs. A 2002 study found poorer quality infant and toddler care in both center-based and home-based care in Iowa compared to other Midwest states. The study concluded that at the time of the survey, Iowa had fewer statewide initiatives to support quality or professional development of the child care workforce than other midwest states.

#### INFRASTRUCTURE BUILDING SERVICES:

8. Need Statement: All children and adolescents should be physically active for at least 30 minutes, limit screen time to no more than two hours, and eat five or more servings of fruits and vegetables each day.

According to the "2002 CDC Pediatric Nutrition Surveillance System," 30 percent of low-income children aged 2-5 years in Iowa are overweight or at risk of becoming overweight and 61 percent of Iowa adults are overweight or obese. In Iowa, the obesity rate in adults has increased by 70 percent from 1990 to 2002. In the needs assessment prioritization process, stakeholders ranked improve physical fitness of children as the #4 priority need.

A review of submitted Community Health Needs Assessment and Health and Improvement Plans revealed a collective top priority of related factors: overweight, nutrition, and physical activity. There are 63 counties focusing efforts around these issues.

9. Need Statement: Reduce the number of infant deaths due to prematurity.

Infant mortality is a critical indicator of the health of a population, as it reflects the overall state of maternal health, as well as the quality and accessibility of primary health care available to pregnant women and infants. Advances in medical technology and access to care have produced declines in infant mortality rates across the country, including Iowa. In the Title V needs assessment prioritization

process, reduce infant mortality was ranked as the #8 priority need by stakeholders.

Provisional data for calendar year 2004 points to a potential decrease in the rate of infant mortality per 1,000 births, from 5.7 in 2003 to 5.0 in 2004.

In the Community Health Needs Assessment and Health Improvement Plan, 15 counties are addressing prenatal care and birth outcomes.

10. Need Statement: Assure pregnant and parenting women are screened and referred to appropriate mental health services.

The IDPH Women's Health Information System contained records for 9,344 women in 2004. The top needs listed by the women were emotional and social needs (7.6%), language/cultural barriers (3.9%), and domestic violence assistance (3.1%).

A review of the Community Health Needs Assessment and Health Improvement Plan indicated that 14 counties are addressing mental health issues, such as poor access to services and health professionals, limited number of rural psychiatrists for adults and children, and inadequate mental health screening.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99.2	99.5	99.5	99.5	99.7
Annual Indicator	100.0	99.1	99.4	100.0	100.0
Numerator	38170	37412	37598	47	43
Denominator	38170	37756	37815	47	43
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	99.8	99.9	99.9	99.9	99.9

### Notes - 2002

FFY02 data were obtained from the Neonatal Metabolic Screening Program.

### Notes - 2003

FFY02 data were obtained from the Neonatal Metabolic Screening Program. Total births is by occurrence.

### Notes - 2004

FFY04 data were obtained from the Neonatal Metabolic Screening Program.

#### a. Last Year's Accomplishments

The performance objective of 99.5 percent was met. Data provided to the Center for Congenital and Inherited Disorders and the Iowa Neonatal Metabolic Screening Program (INMSP) indicates that 100 percent of all Iowa newborns that are confirmed for genetic and metabolic conditions are also treated.

#### Infrastructure Building Services

The 2004 General Assembly enacted legislation effective July 1, 2004, that renamed the Birth Defects Institute to the Center for Inherited and Congenital Disorders. Additionally, the Center has been relocated within the Bureau of Family Health in the Division of Health Promotion and Chronic Disease Prevention.

Heel Stick News, a semi-annual statewide newsletter, was developed to provide information about newborn screening activities. The target audience for the newsletter includes maternity and ob nurse managers, lab managers, physicians, physician assistants, nurse practitioners, midwives, hospitals, and birthing centers.

The INMSP Healthcare Practitioner's Manual on the Center for Congenital and Inherited Disorders Web site was updated. This manual is a guide created to help the practitioner comply with Iowa rules and to better understand the Iowa Neonatal Metabolic Screening Program. The manual includes information on specimen collection, when to obtain a second sample, frequently asked questions, and additional helpful information. The Web site for the Center for Congenital and Inherited Disorders is <http://www.idph.state.ia.us/genetics>.

#### Population-Based Services

The Iowa Neonatal Metabolic Screening Program is a fee-for-service program that provides laboratory, follow-up, consultative, and educational services. Responsibility for the Neonatal Metabolic Screening program is assigned to the State Hygienic Laboratory at the University of Iowa. All newborns and infants born in Iowa are screened for medium chain acyl Co-A dehydrogenase deficiency, phenylketonuria, and other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry; hypothyroidism; galactosemia; hemoglobinopathies; congenital adrenal hyperplasia; and biotinidase deficiency.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn metabolic screening records will continue to be matched with birth certificate records to identify newborns that were not screened.				X
2. Continue to provide follow-up services to ensure infants who were missed receive a screen.			X	
3. Continue to distribute the quarterly Heel Stick News.				X
4. Continue to update and maintain the INMSP Healthcare Practitioner's Manual.				X
5. Continue to convene the Newborn Screening Advisory Committee.				X
6.				
7.				
8.				
9.				

## b. Current Activities

### Infrastructure Building Services

Newborn metabolic screening records are matched with birth certificate records to identify newborns that were not screened. To facilitate this process, a Web-based matching system continues to be under development. A temporary system has been developed to identify unscreened newborns and infants. When an unscreened newborn is identified, the birthing facility and/or physician's office is contacted to determine the reason that the newborn was not screened. If a missed screening is identified, the birthing facility/physician's office arranges for the newborn to be screened.

The Iowa Neonatal Metabolic Screening Program is collaborating with the Child Death Review Team to develop a notification system for child deaths to decrease unnecessary contact of families.

Iowa's 2005 81st General Assembly approved legislation that appropriates \$160,000 to the Metabolic Formula program to assist individuals with metabolic diseases in the purchase of metabolic formula and medical foods necessary for management of their disorder.

Legislation was also considered that would require third party payors to provide coverage for metabolic formula and medical foods. This bill did not make the funnel deadline, and will not be up for consideration in future sessions.

### Population-Based Services

The program continues to investigate the possibility of including additional disorders in the newborn metabolic screening panel. One of the disorders currently in pilot testing is cystic fibrosis.

IDPH was awarded a cooperative agreement from CDC in September 2002 to perform surveillance and long term follow up of disorders identified by MS/MS. The program is currently working with the CDC and the state of Oregon to protocols.

## c. Plan for the Coming Year

### Infrastructure Building Services

The Iowa Neonatal Metabolic Screening Program will continue to improve the capacity to ensure uniform short-term follow-up and to monitor identified newborns through adulthood, and work with the University of Iowa Department of Pediatrics to improve long-term follow up of diagnosed newborns.

The Center for Congenital and Inherited Disorders is working with the CDC on a major initiative to develop a system for the collection of data and the surveillance of stillbirths. Implementation is planned during FFY06.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			40	59.2	59.9
Annual Indicator			58.6	58.6	58.6
Numerator			225	225	225
Denominator			384	384	384
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	60.6	61.3	62	65.1	68.4

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

The FFY04 performance objective of 59.9 percent was not assessable because the Population-Based Services national CSHCN survey has not yet been repeated. Based on the survey's previous administration, the FFY02 indicator value = 58.5 percent.

#### Infrastructure Building Services

New leadership for the CHSC Family Participation Program was established. A prior outsourcing arrangement with a multi-agency family advocacy organization was determined to be unsatisfactory. The new leadership structure involves co-leaders selected from within the CHSC parent consultant network. Full participation on the CHSC Leadership Council has been assumed by the co-leaders.

Family participation in the Iowa Medical Home Initiative (IMHI) continued using family members of CSHCN as members of the project's Core Advisory and Action Group and as advisors directly to the medical home practices. These families contribute feedback to the IMHI project team and, in some instances, help primary care practice staff plan their medical home goals.

A parent of a child with special health care needs who is an active member of Iowa's MCH Advisory Council attended the national Champions for Progress conference. This parent will help facilitate system development around the six national outcomes for CSHCN.

#### Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporate a family perspective in planning and executing a new				

Learning Collaborative opportunity to promote quality improvement in primary care practices.				X
2. Increase involvement of CHSC parent consultants in assisting families receiving various Medicaid Waiver services.		X		
3. Continue to emphasize family participation in program planning, especially through representation on the CHSC Leadership Council.				X
4. Review and establish roles and responsibilities of the CHSC parent consultant network in CHSC direct service activities (e.g. Integrated Evaluation and Planning Clinics and Birth to Five Program services).	X			
5. Incorporate family assessment components in the evaluations of the Iowa Medical Home Initiative and a pediatric behavioral health access improvement project.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services

In FFY05, the CHSC parent consultant network participated in the Title V five-year needs assessment activities. The network co-leaders familiarized themselves with the needs assessment process and then took responsibility for guiding the process with the network members. The family representatives to the MCH Advisory Council also participated in the Title V five-year needs assessment as part of the Council.

The CHSC Family Participation Program is currently engaging in the Iowa I.D.E.A. Part C (Early ACCESS) Program. The parent consultants will be instrumental in planning and implementing CHSC's service coordination role with Early ACCESS.

The new co-leaders for the CHSC Family Participation Program are reviewing and establishing training and meeting schedules for the CHSC parent consultant network. Title V resources will be made available to support training activities, both in-person and via the fiberoptic network.

Due to current budget difficulties, CHSC has mobilized a major education and advocacy effort directed at the state executive and legislative branches. The CHSC Family Participation Program provides family stories illustrating the importance of Title V in the lives of children and families. The Family Participation Program co-leaders are performing the organizational and logistical work necessary to maximize the influence of families in assuring a quality system of services for Iowa's CSHCN.

#### c. Plan for the Coming Year

##### Infrastructure Building Services

In FFY06, the new CHSC Family Participation Program leadership will continue efforts to define roles, expectations, and standards for performance of the parent consultant network. Although participation is increasing, the network remains an underutilized resource that has substantial potential for improving the enabling and Infrastructure Building Services activities of the Title V CSHCN Program.

Assess effectiveness of resources and communication strategies intended to involve families of CSHCN in formulating and influencing public policy relevant to service systems for CSHCN.

Formulate family roles in any learning collaboratives designed to improve chronic illness management skills by primary care providers using a medical home model.

Continue to explore options for increased financial support for parent consultants participating in professional development opportunities and Infrastructure Building Services activities.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			50	58.2	59.4
Annual Indicator			57.1	57.1	57.1
Numerator			413	413	413
Denominator			723	723	723
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	60.6	61.8	63	66.2	69.5

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

The FFY04 performance objective of 59.4 percent was not assessable because the Population-Based Services national CSHCN survey has not yet been repeated. Based on the survey's previous administration, the FFY02 indicator value = 57.1 percent.

#### Infrastructure Building Services

The Iowa Medical Home Initiative (IMHI) expanded its facilitation team with the addition of three 0.3 FTE nurse advisors. This gives the IMHI improved geographical access to primary care practices interested in pursuing a medical home model of care.

The IMHI increased to five the number of primary care practices involved in facilitation to

establish medical home models in three primary care pediatric practices. An additional eight practices are considering participation, but have not yet formally agreed.

A Core Advisory Group for the IMHI was renamed (Core Advisory and Action Group) and restructured to create a greater task orientation. The consolidated the previous six task subgroups into two larger subgroups -- one focusing on "Clinical Issues" and the other on "Measurement Strategies." The restructuring should allow more effective problem identification and planning.

Project partnerships were developed between the IMHI and the Assuring Better Child Health and Development project (to increase developmental screening and early intervention by primary care providers) and the Early Childhood Comprehensive Systems project (to develop a statewide early childhood service system).

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue support for all primary care practices participating in the Iowa Medical Home Initiative (IMHI) through both direct facilitation and Learning Collaborative approaches.				X
2. Continue evaluation activities to document processes and outcomes of efforts to establish medical homes in primary care practices.				X
3. Reconceptualize, in light of a new Integrated Services system development grant, the composition and roles of a stakeholder advisory group for the IMHI.				X
4. Plan and implement a statewide Learning Collaborative for primary care practices interested in pursuing a medical home standard and other practice-based quality improvements.				X
5. Continue collaboration between the IMHI and the Iowa Early Childhood Comprehensive Systems project (Dept of Public Health), Part C Program (Dept of Education), and Assuring Better Child Health and Development project (Dept of Human Services).				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services

In FFY05, eight additional primary care practices joined the IMHI (bringing the total participating practices to 13) with the intention of attaining practice improvement goals and establishing a medical home model of care with assistance from the facilitation team.

The three additional part-time project nurse advisors have undergone intensive training in rapid cycle change strategies to facilitate quality improvement efforts among participating primary care practices.

The IMHI evaluation team gave poster presentations at the national conferences of the

American Public Health Association and the American Evaluation Association. The evaluation team has begun planning an approach to an economic analysis of the IMHI. A small evaluation study was completed to better understand the reasons why practices accept or decline the invitation to participate in the medical home facilitation experience.

### c. Plan for the Coming Year

#### Infrastructure Building Services

In FFY06, as an adaptation to declining resources available per practice, it is expected that a medical home learning collaborative experience will be made available to 20-30 additional primary care practices. If additional grant support is received, more extensive learning collaborative experiences will be available, as will dedicated efforts to assure that all primary care practices have established links to Title V care coordination services.

The IMHI evaluation team will perform an economic analysis of the IMHI; an evaluation of the learning collaborative; and will continue strategies to disseminate project evaluation results.

The IMHI will implement a recognition program to acknowledge the early adopter practices and to promote further spread of the medical home model.

Review the composition of the IMHI Core Advisory and Action Group in light of any and all sustainability strategies.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective			93	63.9	63.3
Annual Indicator			64.5	64.5	64.5
Numerator			468	468	468
Denominator			726	726	726
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	67.7	71.1	74.7	78.4	82.3

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. The projected target objectives decrease for two years based on assumptions of continuing state financial difficulties

and consequent limitation of Medicaid benefits. Patient migration from Medicaid managed care to traditional Medicaid may help alleviate problems with inadequate coverage.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

The FFY04 performance objective of 63.3 percent was not assessable because the Population-Based Services national CSHCN survey has not yet been repeated. Based on the survey's previous administration, the FFY02 indicator value = 64.5 percent.

#### Enabling Services

CHSC continued to facilitate the elective transition of families of children with special health care needs from Medicaid managed care to traditional Medicaid. This activity is based on families' preference for and greater satisfaction with Medicaid fee-for-service plans.

#### Infrastructure Building Services

Wellmark Blue Cross and Blue Shield was a consistent participant on the Iowa Medical Home Initiative Core Action and Advisory Group. Wellmark's participation is essential to generate, deliberate, and implement sustainable office-based quality improvements for children with special health care needs enrolled in primary care practices. Medicaid was an occasional participant on the same group.

CHSC participated in a new Medicaid-led grant project (Assuring Better Child Health and Development), a goal of which is to assure that families receive reimbursable developmental screening and early intervention services for their young children, 0-3 years old.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue availability of the CHSC Director to CYSHCN-related advisory committees for the Iowa CHIP Program (hawk-i).				X
2. Continue to facilitate, as desired by families, disenrollment of CYSHCN from managed care Medicaid and reenrollment in fee-for-service Medicaid.		X		
3. Continue to encourage innovative insurer reimbursement strategies for services provided under medical home practice standards.				X
4. Define the population of "medically fragile" children enrolled in Medicaid Waiver Programs for whom CHSC is contracted to provide care coordination services.				X
5. Participate in insurance-related initiatives to develop chronic illness management protocols applicable to CYSHCN plan enrollees.				X
6.				
7.				
8.				

9.				
10.				

## b. Current Activities

### Enabling Services

In FFY05, CHSC continues to facilitate the elective transition of families of children with special health care needs from Medicaid managed care to traditional fee-for-service Medicaid.

Due to a decreased Medicaid contract, CHSC geographically consolidated its Medicaid Waiver care coordination staff and also increased caseloads.

### Infrastructure Building Services

The University of Iowa Public Policy Center published an "Insurance Policy Brief" detailing the health and dental insurance status of Iowa children, including children with special health care needs. The basis for the policy brief was data from the 2000 Iowa Child and Family Household Health Survey, a statewide Population-Based Services random sample survey supported by an MCHB State Systems Development Initiative grant.

CHSC continues to provide a staff liaison to the Covering Kids and Families Coalition. The Coalition is supported by a Robert Wood Johnson grant and has the overall purpose of increasing health care coverage for Iowa's children and families.

CHSC continues to participate in a Medicaid-led grant project (Assuring Better Child Health and Development) to assure that families receive reimbursable developmental screening and early intervention services for their young children, 0-3 years old. A focus of the project is to address any identified Medicaid barriers to coverage and reimbursement for developmental screening.

## c. Plan for the Coming Year

### Infrastructure Building Services

In FFY06, CHSC intends to participate in a study to analyze the effects of care coordination services provided for enrollees in Medicaid Waiver Programs. Study results should help guide and prioritize Medicaid resource allocation and contracts.

The Iowa Medical Home Initiative will continue working with third-party payers, Wellmark, Medicaid, and possibly others, regarding innovative chronic illness management practices consistent with the concept of a high quality, cost-effective medical home standard of care for children with special health care needs. The Wellmark Foundation will contribute funds to the Iowa Academy of Family Physicians in support of a statewide learning collaborative to spread the medical home concept among community-based primary care practices.

The Iowa Medical Home Initiative evaluation team intends to design and conduct an economic analysis of the project.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]				

<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective			67	79.4	81
Annual Indicator			77.8	77.8	77.8
Numerator			301	301	301
Denominator			387	387	387
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	82.6	84.3	86	87.7	89.4

#### **Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

#### **Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### **Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### **a. Last Year's Accomplishments**

The FFY04 performance objective of 81.0 percent was not assessable because the Population-Based Services national CSHCN survey has not yet been repeated. Based on the survey's previous administration, the FFY02 indicator value = 77.8 percent.

#### **Direct and Enabling Services**

The Continuity of Care Program, a cooperative effort of CHSC and the Children's Hospital of Iowa to improve coordination of hospital and community-based services for families, increased its enrollment roster to approximately 400 children with highly complex conditions.

Presentations continued to senior staff of the Children's Hospital of Iowa documenting program benefits to patients, families, local providers, and the hospital.

#### **Infrastructure Building Services**

CHSC reviewed and revised its Birth to Five Program with the purpose of making the program more accessible and responsive to the needs of Iowa families with young children in the context of the larger statewide early childhood system development efforts.

The Creston Behavioral Health pilot project was completed and data analysis to assess the effects of the innovative service delivery model -- intensive care coordination plus telepsychiatry consultation - was begun. The infrastructure for the pilot project and its potential spread is due to a partnership between CHSC and Magellan Behavioral Health Corp. The partnership established a Web-based statewide video camera network to improve access to services for families.

CHSC's director participated in an executive branch effort to design a statewide system for children's mental health services.

CHSC staff led an effort to design new "service coordination" protocols to facilitate CHSC's participation in Iowa's Part C (Early ACCESS) Early Intervention Program.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain advocacy efforts for a Continuity of Care Program to assure smooth transitions of CYSHCN discharged from major medical centers to community-based services.				X
2. Plan a research study to ascertain the health status, health service utilization, and cost benefits associated with an innovative pediatric behavioral health access improvement project.				X
3. Continue to expand use of telehealth technology to increase ease of access to community-based physical and behavioral services.	X			
4. Enhance the capabilities of CHSC parent consultants to offer quality care coordination services to families receiving Medicaid Waiver or Part C services.		X		
5. Plan and initiate an approach to link all of Iowa's community-based primary care practices to designated Title V care coordinators.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services

In FFY05, preliminary analysis of the Creston Behavioral Health pilot project was completed and plans are in progress to report the results and possibly expand the study. New support from the Magellan Behavioral Health Corp. will support the infrastructure to maintain provider and family access to telepsychiatry consultation services.

The CHSC director continues to participate in an executive branch effort to design a statewide system for children's mental health services.

The CHSC Health and Disease Management Program, which provides care coordination to complex CSHCN enrolled in Medicaid Waivers, was geographically restructured due to a decrease in the Waiver contract.

One activity of the Iowa Medical Home Initiative involves linking primary care providers and Title V community-based staff to enhance a practice's ability to provide care coordination to families of patients with special health care needs.

The new Part C (Early ACCESS) service coordination protocols are in the process of being pilot tested using CHSC parent consultant staff as designated service coordinators. Structured interviews will occur with service coordinators and family members receiving the service.

### c. Plan for the Coming Year

In FFY06, the evaluation results of the Creston Behavioral Health pilot project will be reported and disseminated to Iowa stakeholders and possibly to a wider audience. Given resource availability, an expanded study of the behavioral health access model will be undertaken. Longer outcome measures and more attention to a comparison group will be emphasized.

Efforts will continue, perhaps accelerate given additional resources, to link primary care providers and Title V community-based staff to enhance practices' capacity to provide care coordination to families of pediatric patients with special health care needs.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective			10		
Annual Indicator			5.8	5.8	5.8
Numerator			310	310	310
Denominator			5351	5351	5351
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	6.4	7	7.7	8.5	9.4

#### Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Child Health Specialty Clinics is the recipient of an MCHB grant, "Adolescent Transitions: Health & Ready to Work." The project is developing a transition model in Black Hawk County for adolescents with special health care needs. Accessing health care and finding and maintaining employment are cornerstones of the model. Establishing medical homes for transitioning adolescents is also an important project goal. Selected specific activities are noted in Figure 4a. Unfortunately, the population-based "2000 Iowa Child & Family Household Health Survey" did not include survey items specifically inquiring about transition needs and plans of adolescents with special health care needs. If the survey is repeated, such items could be added.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

## Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

### a. Last Year's Accomplishments

In FFY04, there was no performance objective. This is because the previous national CSHCN survey was unable to produce a reliable state-specific estimate for this performance measure. In FFY02, Iowa chose to report the national performance measure indicator value of 5.8 percent. Iowa hopes that a reliable state indicator estimate is obtained when the national survey is repeated.

#### Infrastructure Building Services

Iowa's Healthy and Ready to Work (HRTW) project continued its collaboration with Waterloo schools, business partners, and supported employment providers to match adolescent participants with pre-employment and employment experiences. Using local service providers, such as the Waterloo Employment Development Council, has been a successful strategy due to their understanding of the Waterloo community, knowledge of which employers are hiring, and use of community supports for working youth with special health care needs.

HRTW care coordinators placed special emphasis on integrating health into the Individual Education Plans used for students enrolled in school-based special education programs.

Eight HRTW participants and advisors participated in all sessions of Living Well and Staying Healthy, a 10-session health and wellness program incorporating career planning and intended to reduce the incidence of secondary conditions for youth with special health care needs.

Evaluation methods and instruments were used to assess system-level and individual changes, both in the project and in a matched comparison group.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include lessons learned from the Iowa Health & Ready to Work Project in the Learning Collaborative "change packages" to improve quality in primary care practices.				X
2. Incorporate the transition concepts of "self-determination" and "independent support broker" in the training curriculum for all Title V care coordinators working with primary care practices.				X
3. Continue advocating for private and public insurance-related innovations that allow adolescents to attain and maintain independent adulthood.				X
4. Investigate developing an advisor role for youth with special health care needs in the Learning Collaborative experience for primary care practices.				X
5.				
6.				
7.				
8.				
9.				

## b. Current Activities

### Enabling Services

In FFY05, the HRTW project, located in Waterloo, Iowa, provides customized care coordination to approximately 48 enrolled youth with special health care needs.

### Infrastructure Building Services

The Living Well and Staying Healthy curriculum for adolescents is being tested in other Iowa communities and is expected to be widely available throughout the state.

To build linkages between medical providers, employers, and educators, HRTW continues to sponsor presentations on adapting school and work settings for students who use medical technology.

The Youth Advisory Council provides considerable feedback concerning recommended changes in medical and educational practices, personal finance issues, and employment opportunities.

Adolescent transition has been proposed as a focus area for any upcoming statewide learning collaboratives dedicated to spreading the medical home concept among community-based primary care practices serving children and adolescents with special health care needs

## c. Plan for the Coming Year

### Infrastructure Building Services

In FFY06, HRTW project funding will have expired; however, it is expected that there will be residual regional and national dissemination of best practices and other relevant experiences gained during this long-term project effort.

HRTW evaluators will fully exercise and analyze the quasi-experimental evaluation design, which compares project-related changes, systemic and individual, with those of a matched comparison group. The evaluation will ultimately highlight processes and outcomes that stand to be most useful to program planners.

The Iowa Medical Home Initiative will include adolescent transition as a focus area (i.e. a charter option) for any upcoming statewide learning collaboratives dedicated to spreading the medical home concept among community-based primary care practices.

**Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	90	90	91	91

Annual Indicator	84.4	86.0	89.0	91.4	93.6
Numerator	17446	15173	6786	6222	5968
Denominator	20663	17635	7625	6805	6374
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	94	94	94	95	95

#### Notes - 2002

Data were obtained from the Clinic Assessment Software Application.

#### Notes - 2003

Immunization data are collected from January 2003 to December 2003 from public sector data.

#### Notes - 2004

Immunization data are collected from January 2004 to December 2004 from public sector data.

#### a. Last Year's Accomplishments

The FFY2004 performance measure of 91 percent was met. Data from January through December 2004 indicates that 94 percent of the children assessed in public sector clinics were appropriately immunized by age 2.

#### Infrastructure Building Services

Collaborative efforts continue between the IDPH Bureau of Family Health, the IDPH Bureau of Disease Prevention and Immunization, and the Iowa Department of Human Services to improve Population-Based Services immunization tracking in Iowa.

#### Population-Based Services

There were 55 new private provider clinics enrolled in the Immunization Registry Information System (IRIS) in 2004. As a result, over 400 immunization clinics throughout Iowa were utilizing IRIS to record immunizations given in local public health agencies, community health centers, private provider clinics, and hospitals. As of December 31, 2004, there were 141,042 children less than 6 years of age that had records in IRIS, representing 68 percent of the state population of this age cohort.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote collaboration between local contract agencies and WIC clinics to provide immunizations.	X			X
2. Continue to promote the use of IRIS to private medical providers.				X
3. Continue to provide immunization trainings and in-services to VFC providers.		X		
4. Continue to provide EPSDT care coordination services at the local level to monitor immunization stats and offer counseling and referral.		X		X
5.				

6.				
7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services

Funding is provided to local public health agencies and community health centers for immunization services. Some agencies will be conducting satellite clinics and collaborating with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to provide immunizations. Private medical providers are encouraged to use the Immunization Registry Information System (IRIS). There are now 301 private provider clinics, 57 Federally Qualified Health Centers/Rural Health Centers, and 17 maternal child health clinics enrolled in IRIS. The goal of the Bureau of Disease Prevention and Immunization is to enroll 100 new providers in 2005. Immunization trainings and in-services will be provided to VFC providers. Local child health agencies continue to monitor immunization status and offer counseling to families receiving EPSDT care coordination services. This includes Title XIX/Medicaid clients not served by an HMO.

Local MCH contract agencies are encouraged to provide immunizations at WIC clinics when possible. A computer tape match between WIC and Immunization records identifies children enrolled in WIC who are not up-to-date on immunizations. WIC staff members support the parents in making arrangements for immunizations.

The Bureau of Disease Prevention and Immunization is advocating for a state mandate requiring insurance companies to cover immunizations according to the standards set by the Advisory Committee on Immunization Practices.

## c. Plan for the Coming Year

The number of private providers using the Immunization Registry Information System (IRIS) will continue to increase. Local child health agencies will continue to monitor immunization status and offer counseling to all families served by EPSDT fee for services, Medipass, and Title V. The Iowa Department of Public Health and the Iowa Department of Education will collaborate on a data exchange between the representative data systems to assure complete immunization records of the children in the local school districts.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	21.7	21.6	16.4	16	15

Annual Indicator	17.2	16.4	15.7	14.9	14.8
Numerator	1136	1049	1006	912	895
Denominator	66000	64011	64011	61361	60369
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	14.7	14.7	14.6	14.5	14.5

#### **Notes - 2002**

Vital Statistics 2002 Provisional data

#### **Notes - 2003**

Vital Statistics 2003 Provisional data

#### **Notes - 2004**

Data were obtained from Vital Statistics 2004 Provisional Data.

#### **a. Last Year's Accomplishments**

The FFY04 performance objective of 15 per 1,000 was met. Iowa's 2004 data indicate that the birthrate for teenagers aged 15-17 years old was 14.8 per 1,000.

#### **Infrastructure Building Services**

In FFY 2004, Iowa continued to provide abstinence education through two sources of federal funds - Section 510 and SPRANS (Special Projects of Regional and National Significance) both under Title V of the Social Security Act. Section 510 continuation funding was made available to existing grantees through a non-competitive application process. The University of Iowa School of Social Work continued to evaluate the program and additional program data was gathered utilizing the SPRANS data collection system. Continuation funding for SPRANS abstinence education allowed three community-based projects to implement programs for adolescents ages 12 through 18 years primarily through curriculum-based instruction but also included community involvement, mentoring, and media. SPRANS Abstinence Education activities also included a data collection system pertaining to the federal performance measures, an abstinence education Statewide Steering Committee, and collaborative efforts with other SPRANS Abstinence Education recipients that implement programs in Iowa.

Iowa is exploring the research on science-based practices in pregnancy prevention. Science based practices include techniques, characteristics, activities, and programs for which there is evidence of effectiveness. The term science-based refers not only to the type of program (for example, a teen pregnancy prevention program based on social science research) but also to the process for developing a program.

#### **Enabling Services**

Family Planning efforts included engaging teenagers through outreach and educational programs. The educational programs stressed the value of abstinence, encouraged adolescents to talk with their parents about sexuality issues, emphasized responsible decision-making skills, avoidance of coercive sexual activity, and provided information related to pregnancy and STD/HIV prevention. IDPH contracts with eight Family Planning grantees to serve 45 of the 99 counties. IDPH collaborates with the other state-level Title X Family Planning grantee to support staff in continuing education and outreach activities.

#### **Direct Health Care Services**

A focus of Family Planning programming was to provide clinical services to adolescents. One of the goals for the IDPH Family Planning program was to maintain the number of adolescents served at 5,547 clients (2004 data 5,277 clients). In the past five years, the number of adolescents served has increased annually. This years numbers decreased due a clinic closi

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Title X Family Planning services and education to adolscents.		X		
2. Continue curriculum-based abstinence education instruction within Iowa school districts through the SPRANS Abstinence Education program.		X		
3. Continue community-based programs under Section 510 Abstinence Education.		X		
4. Participate in national initiatives to promote adolescent pregnancy prevention and the importance of parent/child communication about sex.		X		
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services

For FFY04, federal administration of the abstinence education programs shifted from the Health Resources and Services Administration (HRSA) to the Administration for Children and Families (ACF). Iowa continues its participation in both Section 510 and SPRANS Abstinence Education. Section 510 funding was made available to existing contractors, who also have an opportunity to apply for additional funding through a Request for Bid. The SPRANS project continues to fund three community-based projects that implement programs for adolescents ages 12 through 18. Eight local MCH contract agencies are involved in abstinence education.

In early 2004, the Iowa Department of Human Services (DHS) submitted a request to waive section 1115 of the Medicaid rules to the Center for Medicare and Medicaid (CMS). The waiver request is to extend Medicaid coverage for only family planning services for women who had Medicaid covered pregnancies and deliveries and for all women in Iowa aged 13 to 44 years whose income is below 200 percent of poverty. Eligibility for the expanded Medicaid family planning coverage will be determined at family planning clinics as well as DHS offices.

In early summer 2004, the CMS directed the Iowa Medicaid Program to modify its intergovernmental transfer of funds (IGT) policy and held up approval for the 1115 waiver request until the IGT issue is resolved. The Iowa General Assembly and Governor Vilsack, in collaboration with the DHS, developed a plan to modify Iowa's IGT policy during the recent legislative session. It is expected that the new IGT policy will be approved by July 1, 2005 and along with that approval for the 1115 waiver request as well. DHS is planning training for family planning contract agencies in determining Medicaid eligibility and in accessing the Medicaid web site to enter family planning clients onto the Medicaid system. When the waiver is implemented, IDPH anticipates that the increased Medicaid revenue for family planning

services will improve the family planning contract agencies' financial statuses and will allow them to spend their Title X funds to serve more immigrants and males.

IDPH endorses a five-year project that will facilitate the implementation of strategies for the adoption and use of science-based practices in the design, development, and implementation of all adolescent pregnancy prevention, abstinence education, teen parent, and sexual health education programs offered in Iowa. Touchstones - Sexual Health Measures that Matter is a project of FutureNet.

#### Enabling Services

The Section 510 and SPRANS Abstinence Education programs are being implemented through the same methods as previous years. The continued focus of SPRANS Abstinence Education is curriculum implementation.

#### Direct Health Care Services

Providing clinical services to sexually active adolescents continues to be focus of Family Planning programming in Iowa.

### c. Plan for the Coming Year

#### Infrastructure Building Services

The Iowa Department of Public Health has submitted a competitive application for the Community Based Abstinence Education Program to the Association of Children and Families for FFY06. Section 510 will also be submitting an application for funding. The proposal for Section 510 focuses on making funds available to local contract agencies through a competitive Request for Proposal.

#### Enabling Services

IDPH will contract with eight community-based Family Planning sub-grantees to serve 45 of the state's 99 counties. Family planning efforts will focus on outreach and educational programs towards teenagers. The educational programs will stress the value of abstinence, encourage adolescents to talk with their parents about sexuality issues, emphasize responsible decision-making skills, avoidance of coercive sexual activity, and provide information related to pregnancy and STD/HIV prevention, including all contraceptive methods. IDPH will also continue to collaborate with the other state-level Title X Family Planning grantee to support outreach activities and continuing education opportunities for staff members.

IDPH will participate in two national initiatives, "Let's Talk Month" (October 2005) and "Teen Pregnancy Prevention Day & Month" (May 2006). Schools and contract agencies will be encouraged to plan special events and activities during these times to highlight the need to focus on adolescent pregnancy prevention and the importance of parent/child communication about sex.

#### Direct Health Care Services

Title X funding will continue to be used to provide clinical services to sexually active adolescents. Family planning contract agencies have designed specific activities to reach adolescents by partnering with schools, holding extra clinics at convenient times for adolescents, and including adolescents on their advisory committees.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

# Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	40	41	42	43
Annual Indicator	41.4	42.3	39.4	40.0	43.4
Numerator	14829	14891	13259	12513	14577
Denominator	35818	35204	33653	31283	33588
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	44	45	46	47	48

## Notes - 2002

For the fifth consecutive year, the Iowa Department of Public Health completed a survey to determine the prevalence of dental sealants on permanent molars of third-grade children in Iowa.

## Notes - 2003

For the sixth consecutive year, the Iowa Department of Public Health completed a survey to determine the prevalence of dental sealants on permanent molars of third-grade children in Iowa.

## Notes - 2004

For the seventh consecutive year, the Iowa Department of Public Health completed a survey to determine the prevalence of dental sealants on permanent molars of third-grade children in Iowa. See attachment in the State Narrative for survey methodology.

### a. Last Year's Accomplishments

The FFY03 performance objective of 43 percent was met. A statewide survey conducted during the 2004-05 school year indicated that 43.4 percent of children in third grade have at least one dental sealant in a permanent molar. The survey also indicated that 30 percent of Iowa's third graders do not have dental insurance and that it had been more than three years since five percent of the third graders had seen a dentist. Survey methodology and additional findings are reported in the attachment.

### Infrastructure Building Services

The Oral Health Bureau developed and conducted a sealant prevalence survey, using local child health contract agencies, to assess the ability of children to access preventive dental care. In its sixth year, the survey included all new schools, in hopes of confirming past survey results. The Public Health Dental Director position continued to be vacant and recruitment activities also continued.

### Population-Based Services

In FFY2004, the OHB was able to expand the school-based sealant program to seven contractors. The program targets second through seventh grades in schools with a high percentage of uninsured, underinsured, and/or Medicaid-enrolled children. During school year

2003-2004, 4,287 children were examined and over 15,000 sealants were placed. Seventy-five percent of low-income children examined received at least one sealant.

#### Enabling Services:

The OHB conducted a survey of health, care, and educational programs/agencies within the state to determine the oral health education materials currently in use and what materials may be needed. This information will be used in FFY2005 to assist the bureau in assessing how they can meet the educational needs of public health agencies that serve children and families.

In FFY04, 17 local MCH contract agencies had oral health action plans. The focus of these action plans were access to dental care, EPSDT care coordination, and preventive care. All 25 local Child Health Agencies received Title V funds specifically for dental health.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct the annual sealant prevalence survey with third graders.	X			
2. Continue to promote activities to improve systems to assure oral health services for children.				X
3. Contract with local contract agencies for the school-based sealant programs.		X		
4. Provide technical assistance to local contract agencies on oral health issues.		X		
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure-building

The OHB continues to investigate additional ways to increase funding for school-based sealant programs. After more than two years being vacant, the Public Health Dental Director position was filled. Dr. Bob Russell assumed the position in March 2005. He previously worked as a dental director for a community health center in Michigan. He is active in working directly with underserved populations as well as in planning and developing policy initiatives at the local, state, and federal levels to improve oral health access. A new rule change by the Iowa Board of Dental Examiners, which allows public health supervision for dental hygienists, will include annual reporting of dental hygiene services to the OHB. These annual reports will be assessed to help determine the need for and ability to access preventive dental services, such as sealants.

The OHB received a SOHCS grant from HRSA which funded regional meetings in the state to gather input from local stakeholders. Twelve regional meetings were completed in Ottumwa, Mt. Pleasant, Corning, Atlantic, Marshalltown, Boone, LeMars, Storm Lake, Mason City, New Hampton, Davenport, and Cedar Rapids. The purpose of the meetings was to gather input from local stakeholders about oral health needs and community capacity to meet those needs, to

hear recommendations on how to best build local capacity, and to raise awareness about oral health issues.

Over 100 people attended the meetings, included representatives from Title V agencies, Head Start, WIC, Boards of Health, dental and medical associations, hospitals, Proteus, community health centers, and local health coalitions. Several issues were discussed such as financial barriers to care, recruiting and retaining dentists, health system integration, and improved education of both the public and healthcare providers. A summary report will be completed by September 2005. Information gathered at these meetings will assist the bureau in developing oral health demonstration project grants for at least two Iowa communities, funded through HRSA's State Oral Health Collaborative Systems grant.

#### Population-Based Services and Enabling Services

School-based dental sealant contractors will continue to provide follow-up and care coordination for children participating in their programs, including identifying families that may qualify for Medicaid or hawk-i and assisting those families with enrollment. Local contract agencies will continue to be encouraged to use dental vouchers for sealants.

Eighteen local contract agencies are carrying out action plans related to oral health. The agencies continue to focus on dental access, care coordination, recruitment of dentist, and preventive services.

#### Direct Health Care Services

Four contractors are in their final year of the project period for school-based dental sealant programs. The bureau was also able to fund three additional programs in FFY2005.

### c. Plan for the Coming Year

#### Infrastructure-building

Through the SOHCS grant, the OHB will develop an RFP to award grant funds to at least two communities in the state for oral health infrastructure-building projects. The new dental director and OHB staff will continue to work with stakeholders at the state level to improve systems to assure oral health services for children.

#### Population-Based Services, Enabling, and Direct Health Care Services

The OHB will offer a competitive RFP for FFY2006 for school-based sealant programs, in addition to continuing to work with MCH contractors to provide support services for families to assist them in accessing preventive dental services for their children.

The bureau will continue to administer school-based sealant programs in FY06. The OHB will offer a competitive RFP for FFY2006 for school-based sealant programs, in addition to continuing to work with MCH contractors to provide support services for families to assist them in accessing preventive dental services for their children.

These programs improve dental access to Medicaid-eligible children by providing dental examinations and dental sealants to low-income, uninsured, and/or underinsured children in school-based settings. Children identified with untreated decay or no source of regular dental care are referred to local dentists through the EPSDT care coordinator.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	5.8	5.7	3.5	3.4	3.4
Annual Indicator	3.5	3.4	4.1	4.5	6.7
Numerator	19	19	23	26	38
Denominator	550000	564225	564224	572000	569387
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	5	5	4.8	4.8	4.8

**Notes - 2002**

Vital Statistics 2002 Provisional Data

**Notes - 2003**

Vital Statistics 2003 Provisional data

**Notes - 2004**

Data were obtained from Vital Statistics 2004 Provisional Data.

**a. Last Year's Accomplishments****Infrastructure Building:**

The FF04 performance objective of 3.4 per 100,00 was not met. Iowa's 2004 data indicates the rate of death to children age 14 years and younger caused by motor vehicle crashes was 6.7 per 100,000. Iowa believes the increase is due the 15- 16 year old drives and the number of teens riding with th 15-16 year old drivers. In 2004 the kids and teens who died in motor vehicle crashes were not wearing seat belts. Iowa is hoping the new seat belt legislation will help with that piece.

An update to the existing child restraint law was passed during the 2004 legislative session. The law states that a child under one year of age and weighing less than 20 pounds shall be secured in a rear-facing child restraint system. A child under six years shall be secured by a child restraint system or booster seat. A child at least six years and under eleven years shall be secured by a booster seat or safety belt. The upgrade to Iowa's child passenger safety law went into effect on July 1, 2004 and includes an 18-month education phase. During this phase, law enforcement officers will issue warnings only. Tickets for non-compliance will not be issued until January 1, 2006. This period of time gives families the opportunity to make appropriate plans to ensure safe travel with children.

The kick-off of an educational campaign targeting booster seat-age children called 'Boost Your Booty' began. Goals of the campaign include the following:

1. Increase booster seat use results in statewide child passenger survey.
2. Decrease Iowa's death and injury numbers related to motor vehicle crashes of children.

On June 19, sixteen statewide child passenger safety check-up events were held in conjunction with the 'Boost Your Booty' kickoff to promote booster seat use among booster-age children

(ages four to eight). Over 500 child safety seats were inspected by certified technicians, and 450 booster seats were distributed to families needing a booster seat.

The Bureau of EMS provides leadership and coordination of statewide certification training for child passenger safety technicians. Regular trainings continue.

**Population Based:**

In 2003, the Bureau of EMS and the BFH collaborated to provide the AAP curriculum, Moving Kids Safely in Child Care. Funding was provided by the National Highway Traffic Safety Administration. Objectives of this collaboration included training five instructors to give the training to home child care providers on child passenger safety and offering five regional training sessions for Iowa child care providers. The initial training was offered in April 2003. Sixteen child care nurse consultants attended.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide child passenger safety check-ups at events across Iowa.			X	
2. Collaborate with the Bureau of Emergency Medical Services in the coordination of statewide certification training for child passenger safety technicians.				X
3. Support the annual Iowa Child Passenger Restraint Survey.			X	
4. Continue to provide outreach to Iowa child care providers.			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**Infrastructure Building:**

Child passenger safety advocates are working to provide outreach to physicians. Outreach efforts include providing printed materials such as posters, growth charts, and magnets informing families about appropriate types of child passenger safety systems at various ages and sizes of children. Nearly 2100 physicians have been contacted statewide. Physicians are able to contact the Iowa Safe Kids Coalition to request free materials. The response by physicians has been considerable and favorable.

**Population Based:**

The University of Iowa Injury Prevention Research Center conducted the 2004 Iowa Child Passenger Restraint Survey. At 37 locations statewide, 5200 children under the age of six years were observed in motor vehicles. A total of 3683 or 70.8 percent of the children were appropriately restrained, which is a decrease of 13.3 percent from the 2003 survey. This one-year decrease can likely be explained by the decrease of observers (from two to one).

The 'Boost Your Booty' educational campaign continues statewide to increase awareness of appropriate use of booster seats. The multimedia campaign includes billboards, television,

radio, and printed public service announcements targeting children of booster seat age, their parents, and other caregivers. Planning has begun to establish a booster seat referral program accessible throughout the state. The program's network will include 94 agencies and the 14 Iowa State Patrol posts. The program started in conjunction with the 'Boost Your Booty' campaign and will remain ongoing through financial support of the Governor's Traffic Safety Bureau. Parents, grandparents, and caregivers can access the booster seat referral program through a toll-free telephone number available 24 hours a day, seven days a week. Since June 2004, over 260 booster seats have been provided to Iowa families.

The Iowa Safe Kids Coalition has conducted almost 30 statewide check-up events this year. Check-up events are held at community events as well as regularly scheduled child passenger safety Fit Stations. To date during FFY05, a total of 2057 child passenger safety seats were checked by certified technicians at statewide events. Of these seats, a total of 1295 or 63 percent, were installed incorrectly. Of all seats checked, 123 were recalled. A total of 617 new seats have been distributed to families.

The Bureau of Emergency Medical Services offers certification and recertification training of child passenger safety technicians throughout the year at statewide locations.

BFH received funding from the U.S. Consumer Product Safety Commission (CPSC) to conduct 20 onsite assessments for an injury prevention pilot project in child care in northwest Iowa. Child care nurse consultants visit early education providers onsite using a Consumer Product Safety Commission-approved checklist to assess hazardous and recalled children's products.

### c. Plan for the Coming Year

#### Infrastructure Building:

Physician outreach regarding child passenger safety will continue. Materials are provided to physician offices at no cost. Physicians have an opportunity to educate families with young children about appropriate child passenger safety systems.

#### Population Based:

The Bureau of Family Health and the Iowa Safe Kids Coalition will collaborate to provide outreach to Iowa child care providers. One strategy includes offering online ordering of materials via the Healthy Child Care Iowa website (<http://www.idph.state.ia.us/hcci/products.asp>).

The University of Iowa Injury Prevention Research Center will conduct the 2005 Iowa Child Passenger Restraint Survey. Results will be shared with stakeholders and advocates statewide.

Training will continue for certified child passenger safety technicians. To date, two technician classes are scheduled in various statewide locations (Sioux City, Des Moines).

Iowa Safe Kids Coalition, the Bureau of Emergency Medical Services for Children, and the Bureau of Family Health will collaborate in the spring of 2006 to offer the curriculum Moving Kids Safely in Child Care to Iowa's network of registered nurse child care nurse consultants. Many new nurse consultants have come on board since the first training in 2003, and Iowa's updated child passenger safety law make 2006 an opportunity for further education of the child care community.

The CPSC-approved Injury Prevention Checklist will be rolled out statewide for use by child care nurse consultants at the statewide Early Care, Health, and Education Congress in November 2005.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	59.7	60	61	61	64
Annual Indicator	63.1	60.2	65.0	65.9	67.0
Numerator	24085	22528	24396	25124	25681
Denominator	38170	37443	37558	38139	38309
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	68	68	68	69	69

**Notes - 2002**

The 2002 breastfeeding rates were obtained from the Iowa Metabolic Screening Profile.

**Notes - 2003**

The 2003 breastfeeding rates were obtained from the Iowa Metabolic Screening Profile.

**Notes - 2004**

The 2004 breastfeeding rates were obtained from the Iowa Metabolic Screening Profile.

**a. Last Year's Accomplishments**

The performance measure for FFY04 of 64 percent was met. Data collected on the Iowa Newborn Metabolic Screening Profile showed that 67 percent of infants were being breastfed at hospital discharge in 2004.

**Enabling Services**

IDPH co-sponsored the annual breastfeeding conference with Iowa Health Systems. IDPH provided leadership for the Iowa Lactation Task Force (statewide breastfeeding coalition).

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Co-sponsor the annual breastfeeding conference.				X
2. Provide leadership for the Iowa Lactation Task Force (statewide breastfeeding coalition).				X
3. Implement a peer-counseling program, using the USDA curriculum				X

and Best Start Social Marketing.				
4. Monitor local contract agency action plans for breastfeeding promotion.				X
5.				
6.				
7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services

The IDPH contract requires local contract agencies to expend a minimum of 20 percent of the total WIC funds on nutrition education, including a minimum of three percent of the WIC funds to be spent on breastfeeding promotion and support.

The Special Supplemental Nutrition Program for WIC received a grant from the Using Loving Support to Build a Breastfeeding-Friendly Community organization, for the period of June 2002 through September 2003 with an amendment of \$25,000 through September 2005. The grant focuses on increasing breastfeeding rates in Iowa by educating local contract agencies and health care professional staff using a train the trainer approach. Trainings were held in May 2004 and October 2004.

The program received a USDA Peer Counseling grant in 2004. The purpose of the grant is to start a peer-counseling program in Iowa. The grant will help pilot the program in one or two local WIC agencies. Evaluation of the pilots will take place before the grant ends in 2006. A general information session will take place in January 2006 followed by training specifically for the pilot programs in April 2006. A peer counselor curriculum developed by USDA and Best Start Social Marketing will be used.

### Direct Health Care Services

Twenty-five of the local contract agencies implemented action plans targeting community-based breastfeeding promotion and support. The following list represents activities of local MCH contract agencies;

1. Collaborate with local OB physicians to increase breastfeeding rates.
2. Provide breastfeeding education and support to communities.
3. Meet and present breastfeeding educational/promotional packets to area businesses.
4. Train staff and local health care professionals with a basic breastfeeding training.
5. Visit area businesses to discuss breastfeeding once mothers have returned to work.

## c. Plan for the Coming Year

### Infrastructure Building Services

The annual breastfeeding conference will be held in May 2006. Workshops will be offered to provide breastfeeding training opportunities at the local level. The Bureau of Nutrition and Health Promotion staff will provide technical assistance on breastfeeding to the local contract agencies. Local maternal health contract agencies will continue to develop and implement community-based strategies for breastfeeding.

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	85	86	88	97
Annual Indicator	62.8	89.5	81.4	93.2	98.9
Numerator	23982	33633	30728	16682	15716
Denominator	38170	37579	37749	17899	15892
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	99	99	99	99	100

**Notes - 2002**

IDPH conducts a survey with OB Hospitals requesting aggregate newborn hearing screening data. Sixty- nine hospitals surveyed responded, indicating 22,922 newborns, representing 85% of the total births, were screened for hearing loss prior to discharge. On January 1, 2004, all OB Hospitals have a mandatory requirement to report newborn hearing screening numbers to IDPH. IDPH is in the process of selecting a new database for newborn hearing screening. This will improve the accuracy for reporting.

**Notes - 2003**

IDPH conducted a survey with OB Hospitals requesting aggregate newborn hearing screening data. Forty-nine of the 89 hospitals responded. The 48 hospitals had 17,837 total births. Of the 17,837 births, 16,642 were screened. This indicates a screening rate of 93 percent. On January 1, 2004, all OB Hospitals have a mandatory requirement to report newborn hearing screening numbers to IDPH. IDPH selected eScreeenerPlus (eSP) as the software for web-based Early Hearing Detection and Intervention surveillance. Hospitals and audiologists will be able to use eSP to manage their screening programs and to report data to the State. eSP makes an integrated hearing record available to public health and medical professionals simultaneously.

**Notes - 2004**

Mandatory universal screening was implemented January 1, 2004. Provisional data are reported from the newly implemented eSP data base which is currently being implemented. Forty-one percent (41%) of the initial screens have been entered into the system. The data include complete reporting from all 3 Level III Perinatal Centers; 3 out of 7 Level II Regional Centers; 4 of 12 Level II Centers, and 4 of 67 Level I Centers. Accordingly, hospitals serving high risk infants are over represented in the sample for the provisional data and Level I centers are under represented.

**a. Last Year's Accomplishments**

The FF04 performance objective of 97 per 100,00 was met. Iowa 2004 provisional data indicates the percent of newborns who have been screened for hearing before hospital discharge is 98.9 percent. All maternity hospitals in the state are now performing screening. Given the progress made under the new law, performance objectives for subsequent years are

revised to reflect the significant improvements realized in the past year.

#### Infrastructure Building Services

On January 1, 2004, legislation became effective that mandates universal newborn hearing screening in Iowa. The legislation also requires that the results of all newborn hearing screenings be reported to the IDPH within six days of the infant's birth and the results from all rescreens and diagnostic assessments for children 0-3 years be reported to the IDPH. The Iowa Early Hearing Detection and Intervention Advisory Committee participated in developing administrative rules that direct implementation of this law.

IDPH selected a new Web-based reporting system for EHDI through an RFP process in early 2004 and is now working toward statewide implementing of the system in hospitals, area education agencies, and audiology offices. The new data system, called eScreener Plus (eSP), will allow for secure, authenticated Web-based data reporting. The data collected will be used for statewide surveillance activities and to track individual babies' progress.

IDPH and the Centers for Disease Control and Prevention entered year five of a five-year cooperative agreement to continue development of the statewide data system. IDPH is working in collaboration with Early ACCESS (IDEA, Part C), Title V, and the Center for Disabilities and Development (CDD) to implement this system and educate providers about data reporting requirements.

The Electronic Birth Certificate (EBC) will be the primary reporting mechanism when it becomes available. When the EBC is implemented, data will be collected on the number of infants screened prior to discharge, the results of the screening tests, and where infants were referred for follow-up, if applicable. Until that time, the EHDI program will continue to use a stand-alone reporting system.

#### Enabling Services

A conference designed for professionals involved in EHDI activities was held in September 2004. This conference provided education for health care professionals about Iowa's newborn hearing screening law, audiology-related technical training, and information about best practices related to managing a screening program.

IDPH continued to contract with CDD for pediatric audiologists to provide technical assistance for establishing newborn hearing screening programs in hospitals and Area Education Agencies (AEAs). In response to Iowa's growing immigrant population, Spanish language brochures were made available.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to convene the Early Hearing Detection and Intervention Advisory Committee on a quarterly basis.				X
2. Continue to provide technical assistance to hospitals and Area Education Agencies (AEAs).		X		
3. Collaborate with Early ACCESS (IDEA, Part C) to assure access to appropriate follow-up services.				X
4. Continue to implement the new statewide data system for newborn hearing screening.				X
5. Collaborate with the CHSC Early Hearing Detection and Intervention				

project.				X
6.				
7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services

Since January 2004, hospitals, area education agencies, audiologists, and other health care professionals providing newborn hearing screening, rescreen, and/or diagnostic services are reporting their results to IDPH. IDPH is working closely with Early ACCESS (Iowa's IDEA, Part C program) to assure that families have access to appropriate follow-up services for their children.

The new EHDI data system, eSP, has been implemented at the IDPH. Hospital screeners and audiologists will begin using the data system later this year. The use of eSP will allow providers to manage their screening programs and to electronically report data to IDPH. ESP makes an integrated hearing record available to public health and medical professionals simultaneously.

On April 1, 2005, the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources and Service Administration (HRSA) awarded an Early Hearing Detection and Intervention grant to Iowa. This grant was awarded to Child Health Specialty Clinics (CHSC). The award provides \$139,000 each year for the three-year period of April 2005-March 2008.

The activities of this grant focus on reducing the number of infants who are "lost" in the system, therefore delaying the provision of early intervention services. The five goals identified in this grant are:

- All newborns will be screened appropriately prior to hospital discharge.
- All audiologic diagnoses will occur before children are three months of age.
- All eligible children will be enrolled in an early intervention program (Part C, Early ACCESS) before six months of age.
- All families with children 0-3 who are deaf or hard-of-hearing or are at risk for late-onset hearing loss will be linked to a medical home.
- All families with children 0-3 who are deaf or hard-of-hearing will receive family-to-family support.

The IDPH recently entered into a three-year cooperative agreement with the Centers for Disease Control and Prevention. The activities of this agreement focus on developing and implementing a statewide EHDI surveillance system. The goals of the project are to:

- Complete the statewide implementation of the EHDI data system.
- Facilitate data integration linkages with related screening, tracking, and surveillance programs.
- Maximize the use of EHDI data for statewide and local decision making.
- Evaluate the Iowa EHDI system based on the performance indicators set forth in the National EHDI Goals and utilize the results to establish project sustainability.

IDPH continues to convene the Iowa Early Hearing Detection Intervention Advisory Committee on a quarterly basis. This committee played a key role in the development of program goals for the next three years. The committee continues to discuss and resolve program issues as they arise.

### Enabling Services

IDPH is in the process of training hospitals, AEAs, and private-practice audiologists to use the new statewide data system, eSP.

### c. Plan for the Coming Year

#### Infrastructure Building Services

During FFY06, Iowa will focus on implementing the activities of the HRSA EHDI grant and CDC EHDI Cooperative Agreement. We will continue to implement eSP in hospitals, AEAs and audiology offices throughout the state. Referral and follow-up procedures for children with hearing loss will be continually reviewed and updated to better serve families.

#### Enabling Services

In FFY06, emphasis will be placed on implementing quality universal hearing screening programs in all birthing hospitals. IDPH will continue to work with CDD audiologists to provide training to hospital and AEA staff across the state. A review of early intervention referral procedures and the provision of early intervention services will be coordinated with Early ACCESS (IDEA, Part C).

### Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	6	6	5	4	3
Annual Indicator	6.1	6.2	4.7	8.6	6.0
Numerator	45000	46000	34000	60028	40826
Denominator	736000	747000	723000	698000	680437
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	5	4	3	3	3

#### Notes - 2002

FFY2002 data were obtained from the current population survey from the U.S. Census Bureau.

#### Notes - 2003

FFY2003 data were obtained from the current population survey from the U.S. Census Bureau.

#### Notes - 2004

As of early July 2005, data from the Current Population Survey for 2004 was not available. The number provided is a three year average uninsured rate. hawk-i and Medicaid enrollment is at an all time high with outreach activities through hawk-i outreach and Covering Kids and Families demonstrating success for enrolling children. We recognize this population still needs to be reached and continue to identify strategies to decrease uninsured rates.

## a. Last Year's Accomplishments

The FFY04 performance objective of three percent was not met. FFY04 data indicates that the percent of children without health insurance was 6 percent. Census data for 2004 was not available. A three year moving average was used for the FF04 data. There are several factors contributing to the increase in the percent of uninsured children in Iowa over the last year. Health insurance costs are increasing for employers and families. As the premiums, deductibles, and co-pays increase, the costs impact both employers and families. Iowa, as the rest of the nation, has continued to see an increased unemployment rate over the past year. This decreases the amount of covered employees and affordability of health insurance for low-income families.

### Infrastructure Building Services

Iowa's SCHIP program, called Healthy and Well Kids in Iowa (hawk-i) is housed in the Iowa Department of Human Services (DHS). In FFY04, DHS continued to contract with the Iowa Department of Public Health for statewide hawk-i outreach activities. To fulfill its responsibilities, IDPH hired a statewide hawk-i outreach coordinator and contracted with already established local child health agencies for community outreach activities. Local outreach coordinators focused their work primarily with vulnerable populations, faith based organizations, schools, and health care providers.

Covering Kids and Families in Iowa is a hawk-i partner project housed in the IDPH. The IDPH Bureau of Family Health continued activities in the second year of this four-year project funded by the Robert Wood Johnson Foundation. In FFY04, CKF created a team to participate in the national process improvement project, convened a task force on barriers to health insurance access for Iowa children, made recommendations for removing those barriers, simplified coverage through an automated referral process, and convened the Outreach Task Force for local outreach coordinators.

Highlights from hawk-i outreach efforts from FFY04 are listed below.

1. Lt. Governor Sally Pederson and Iowa Congressman Leonard Boswell held community roundtables throughout the state to discuss the hawk-i program and outreach efforts.
2. The Association of Iowa Workforce Partners made hawk-i information available in their offices.
3. The Institute for Social and Economic Development made hawk-i information available at Earned Income Tax Credit assistance sites.
4. The First Lady of Iowa, Christie Vilsack, made hawk-i materials available for participants in her kindergarten literacy program.

### Enabling Services

The number of children enrolled in Medicaid and hawk-i continued to increase in FFY04. In Sept. 2004, enrollment for Medicaid expansion was 14,527 children and enrollment in the hawk-i program was 16,931 children. Additionally, the number of Medicaid participants of all ages increased. This was due, in part, to the efforts of local hawk-i outreach workers who referred four out of 10 hawk-i applicants to Medicaid.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to coordinate statewide and local hawk-i outreach efforts.				X
2. Develop issue briefs to encourage educated policy decision-making.				
3. Implement local outreach efforts through action plans related to the				

hawk-i program.				
4. Continue to convene the Outreach Task Force.				
5. Coordinate outreach efforts with the Free and Reduced Lunch Program.				
6.				
7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services

The Iowa Department of Human Services continues to contract with IDPH for hawk-i outreach. Covering Kids and Families (CKF) is in year three of the four-year project period and continues to focus on increasing access to health care for low-income uninsured children. Local outreach coordinators in the child health agencies focus their efforts on the vulnerable populations, faith-based organizations, health care providers, and schools.

Highlights of FFY05 CKF and hawk-i outreach efforts are listed below.

1. Local coordinators conducted back-to-school campaigns in their school districts.
2. A targeted media campaign was held in conjunction with the back-to-school efforts in one of the CKF pilot sites.
3. Training was implemented for the regional coordinators of Iowa's early intervention program, Early ACCESS.
4. Outreach efforts were coordinated with the Free and Reduced School Lunch Program.
5. The Institute for Social and Economic Development continued to provide hawk-i information at Earned Income Tax Credit assistance sites.
6. Cover the Uninsured Week 2005 activities included events hosted by IDPH.
7. Articles were submitted to statewide association newsletters for health care professionals.
8. The Outreach Task Force continued to bring local outreach coordinators together.
9. Issue Briefs were developed to encourage educated policy decision-making.

### Enabling Services

Enrollment numbers for Medicaid and hawk-i are continuing to climb. In May 2005, enrollment for Medicaid expansion was 15,057 and enrollment in the hawk-i program was 19,678.

## c. Plan for the Coming Year

### Infrastructure Building Services

In FFY06, the Iowa Department of Public Health will continue to oversee hawk-i outreach activities under contract with the Iowa Department of Human Services. Covering Kids and Families will enter the final year of the four-year project funded by the Robert Wood Johnson Foundation. Priority activities will focus on development of sustainability plans. The process improvement collaborative team will continue to focus on maximizing the efficiency and effectiveness of Medicaid and hawk-i. The team will examine reasons that families fail to comply with procedures when applying or renewing their coverage. CKF and hawk-i outreach will continue to coordinate statewide back-to-school outreach campaigns, submit regular newsletter articles to associations for health care professionals, and develop a plan for ongoing training of child care providers.

### Enabling Services

In FFY06, outreach to special populations will be enhanced to improve access to quality health

insurance. Local coordination and collaboration between agencies will be improved to eliminate duplication. CKF and hawk-i outreach will work together to coordinate with Community Health Clinics and free clinics to assess what outreach is currently taking place and build upon the current efforts. CKF and hawk-i outreach will engage traditional and non-traditional statewide stakeholders to conduct hawk-i outreach.

CKF and hawk-i outreach will provide educational opportunities for local contract agency staff to develop skills in assessing the number of uninsured children who are eligible for Medicaid of the hawk-i program, and to create a community plan for providing care for those children. CKF and hawk-i outreach staff will offer a breakout session at a statewide conference for local contract agency hawk-i outreach coordinators to discuss program issues and outreach strategies.

**Performance Measure 14:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	85	90	92	94	98
Annual Indicator	89.8	94.7	97.1	98.7	99.7
Numerator	155127	173131	180433	195915	214351
Denominator	172815	182821	185888	198485	214993
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	99.8	99.8	99.8	99.8	99.9

**Notes - 2002**

Data were obtained from the Annual EPSDT Report from the Medicaid HICFA 416 report.

**Notes - 2003**

Data were obtained from the Annual EPSDT Report from the Medicaid CMS 416 report.

**Notes - 2004**

Data were obtained from the 2004 Annual EPSDT Report from the Medicaid CMS 416 report.

**a. Last Year's Accomplishments**

This performance objective of 98 percent was met in FY04. Of Iowa children who were eligible for Medicaid, 99.7 percent received a service paid by the Medicaid program. There were 214,993 eligible children during FY04 and 214,351 received at least one screen.

Infrastructure Building Services

Through the Access to Baby and Child Dentistry (ABCD) program, Title V child health local

agencies were eligible to receive funding to increase access to dental care for Medicaid eligible and other low-income children by building community infrastructure. In FY04, 22 of Iowa's 26 Title V child health agencies received funding and served 84 of Iowa's 99 counties. Four ABCD agencies were also granted additional grant funds to "enhance" their programs, using funds received through the State Oral Health Collaborative Systems grant from HRSA. EPSDT rates of total eligible children 1-20 years in Iowa receiving any dental services increased from 40.4 percent in FY02 to 41.7 percent in FY03.

The "EPSDT Informing and Care Coordination Handbook" was updated. The annual EPSDT Care for Kids conference provided community partners the opportunity to focus on the basic components of informing and care coordination.

#### Enabling Services

The toll-free Healthy Families Line and TEEN Line, sponsored by IDPH and DHS, provided families with information about services provided by Medicaid. Callers were connected directly to the Care for Kids Coordinators in their communities. The Healthy Families Line received 3,321 calls related to the Care for Kids Program last year, which was 613 more than the year before. In summary, 2,889 callers were not familiar with the program, 67 callers needed transportation, 100 callers needed a dentist, 29 callers needed a doctor, 11 callers needed an eye doctor, 2 callers needed an audiologist, and 5 callers requested a Care for Kids brochure. Twelve doctors' offices called with questions about Care for Kids.

Iowa's EPSDT Team participated in development of an application to the National Academy for State Health Policy for ABCD II funding. The application promoted a public-private system of collaborative practice that focused on prevention, early recognition, and early intervention to promote healthy mental development of children birth to age three within Iowa's Medicaid program. Iowa's ABCD II project was funded and was initiated in January 2004. More information on the ABCD II project can be found in the SPM # 11

#### Population-Based Services

In FY04, after a one-year lapse due to decreased funding, Healthy Child Care Iowa again assessed child health care access and safety using a standardized assessment tool. Each child's health record was assessed for presence of medical home, health insurance status, and care received per EPSDT periodicity schedule. Children with identified needs were referred to local contract agencies.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue EPSDT training and technical assistance for local contract agencies' EPSDT coordinators.				X
2. Collaborate with EPSDT coordinators to improve community linkages with local Medicaid providers.				X
3. Continue to sponsor the toll-free Healthy Families Line and TEEN Line to provide Medicaid information.		X		
4. Collaborate with the ABCD II project to promote healthy mental development of children.		X		
5. Monitor local contract agencies action plans related to preventive health services for children.				X
6.				

7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services

Through the ABCD and ABCD-E Programs, Title V child health agencies continue to receive funding to increase access to dental care for Medicaid-eligible and other low-income children by building community infrastructure. The long-term goal of the ABCD program is to improve access to Medicaid-eligible children ages 1-20, with special emphasis on children age 0-5. Based on community needs assessments, local agencies are able to develop individual ABCD and ABCD-E action plans. Activities included outreach, education, improved care-coordination systems, and increased collaboration with local dental providers and community stakeholders.

To promote dental access for all EPSDT children, the Oral Health Bureau staff continues to provide technical assistance and consultation to MCH agencies, WIC programs, schools, health professionals, and community organizations throughout the state. This assistance is achieved through frequent site visits, staff training, presentations, and phone contact. The staff also collaborates monthly on the Iowa Department of Public Health's EPSDT Team and Child Health Team. With technical assistance support from MCHB, the Oral Health Bureau received technical assistance from Dr. Rebecca King, from North Carolina, to present at Iowa's annual Spring Public Health Conference. The title of her presentation was The Physicians Role in Children's Oral Health. Dr. King shared details of how her state has engaged physicians in providing oral health guidance and care, and what role medical colleagues can play in improving access to care for low-income children.

### Population-Based Services

As discussed in the previous section, long-term efforts to establish a state-level agreement with an Iowa Medicaid managed care provider were terminated in FY05. In February 2005, the provider ceased to function as an Iowa Medicaid HMO. In response, state EPSDT staff focused on ensuring that children were not left without care as a result of this change. Local staff focused on building capacity to serve the children.

## c. Plan for the Coming Year

### Infrastructure Building Services

Plans for the coming year will focus on strengthening the interagency collaboration and statewide infrastructure. Local EPSDT care coordinators will be encouraged to improve community linkages with local Medicaid providers for referrals and follow-up for Medicaid children.

The Oral Health Bureau will be collaborating with Head Start/Early Head Start in developing Healthy Smiles, a parent curriculum for home visitors. The Oral Health Bureau will conduct statewide regional meetings to gather local input, engage stakeholders, and raise awareness of oral health issues. The goal is for communities to implement demonstration projects for building local infrastructure to improve access to dental care. These projects will provide model approaches for integrating oral health into existing local systems of care.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

# Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.4	1.4	1.4	1.3	1.2
Annual Indicator	1.3	1.2	1.2	1.2	1.3
Numerator	491	437	444	443	507
Denominator	38170	37597	37749	38139	38369
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	1.2	1.2	1.2	1.1	1.1

## Notes - 2002

Vital Statistics 2002 Provisional Data

## Notes - 2003

Vital Statistics 2003 Provisional data

## Notes - 2004

Data were obtained from Vital Statistics 2004 Provisional Data.

### a. Last Year's Accomplishments

The performance objective of 1.3 percent was met. The 2004 data shows that the overall very low birth rate was 1.2 percent. The very low birth weight rate for blacks has improved, but significant efforts are still needed to address the very low birth weight rates for the black community.

### Population-Based Services and Enabling Services

Beginning in FFY98, reducing racial disparities was the focus of efforts to decrease the incidence of very low birth weight. The black population is the target for these efforts.

Provisional data reflects steady progress. In 1998, the rate of black low birth weight was 13.1, and rate of very low birth weight was 4.2 (per 100 live births). Provisional data for 2004 shows the black low birth weight rate as 10.9 percent, and the rate for black very low birth weight as 3.1 percent.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor the Barriers to Prenatal Care survey and WHIS data for unintended pregnancies.				X
2. Advocate for improved access to early prenatal care for			X	

undocumented (immigrant) women.				
3. Continue to provide leadership and technical assistance to local maternal health contract agencies.				X
4. Monitor outreach activities for local contract agencies.				X
5. Continue to collaborate with the March of Dimes Premature Birth Prevention Campaign and other initiatives.				X
6. Continue to participate in the Statewide Perinatal Care Team facility reviews.				X
7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services

IDPH continues to provide leadership for activities that influence delivery of prenatal services. The BFH continues to monitor the "Barriers to Prenatal Care" survey and WHIS data for unintended pregnancies, entry into prenatal care, risk factors, and socioeconomic factors. The data are evaluated to identify disparities and analyze information about the probable reasons for disparities.

IDPH advocates for improved access to early prenatal care for undocumented (immigrant) women and women in vulnerable populations through the local maternal health agencies. Work continues to reduce the preterm birth rate. IDPH continues to collaborate with the March of Dimes Premature Birth Prevention Campaign and other initiatives, such as pregnancy smoking cessation, and the Statewide Perinatal Care Team.

Iowa participated in the Tobacco Prevention and Cessation Action Learning Lab (ALL) in Washington D.C. in June of 2005. The ALL is a collaborative effort between AMCHP, ACOG, PPFA, and the Women's Tobacco Prevention Network (WTPN), and is supported by the CDC's Division of Reproductive Health and the Robert Wood Johnson Foundation. Five state teams came together to have an increased capacity to advance their state action plans and to evaluate their efforts. The Iowa Team included Linda Railsback, MD, MPA American College of Obstetricians and Gynecologists, Melissa Grant, Planned Parenthood of Greater Iowa, Jerilyn Quigley, Division of Tobacco Use Prevention and Control, IDPH, Stephanie Trusty, Bureau of Family Health, IDPH. Iowa's action plan includes a goal to develop a tobacco intervention model. Emphasis will be on training Planned Parenthood staff to ask all women of childbearing age if they use tobacco, advising them to quit, and providing information on the Iowa Quit line. Iowa is working with Planned Parenthood to develop tools and training materials for assessment and follow-up. Following the implementation an evaluation of the project including both staff compliance and client satisfaction will be completed.

### Enabling Services

IDPH continues to provide leadership for local maternal health contract agencies' prenatal care and health care coordination programs for pregnant women, and work with other agencies to decrease risk factors such as smoking and substance abuse during pregnancy. Local contract agencies conducted outreach activities to improve access to services for hard-to-reach and vulnerable populations. Four local contract agencies have implemented action plans targeting low birth weight. Four additional local contract agencies have action plans that address smoking cessation for pregnant women. In collaboration with DHS, IDPH has implemented changes in Medicaid Administrative Rules to allow reimbursement for local travel to pregnant women for medical appointments. This has helped decrease transportation barriers to access

care for some women.

#### Direct Care

Three agencies are providing direct care services.

### c. Plan for the Coming Year

#### Infrastructure Building Services

The local maternal health agencies will continue to address case finding and outreach to minorities. Local contract agencies specifically target minority populations in their annual action plans. The Bureau of Family Health will continue in its collaborative efforts in Iowa with ACOG, Planned Parenthood, and the IDPH Division of Tobacco Use, Prevention, and Control to examine efforts to decrease smoking during pregnancy.

#### Enabling Services

The Women's Health Information System (WHIS) will monitor the effectiveness of minority outreach activities of the local contract agencies. WHIS will monitor the provision of prenatal services, including enhanced services, to minority populations. The Bureau of Family Health will examine factors that place women at risk for pre-term delivery. Special focus this year will be to provide specific education targeted to women with previous premature birth as documented in WHIS. An informational brochure will be developed to assist with this education.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13.8	13.9	13.8	13.7	11
Annual Indicator	10.6	14.1	7.9	8.9	10.4
Numerator	24	32	18	19	22
Denominator	226000	226420	226420	214000	211983
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	10	10	9.8	9.6	9.6

#### Notes - 2002

Vital Statistics 2002 Provisional Data

#### Notes - 2003

Vital Statistics 2003 Provisional data

#### Notes - 2004

Data were obtained from Vital Statistics 2004 Provisional Data.

#### a. Last Year's Accomplishments

The FFY04 objective of 11 was met. Iowa's 2004 data indicated that the suicide rate for youths aged 15-19 was 10.4. The Child Death Review Team has had discussions about the increase in the rate from 2003 to 2004. They feel the increase may be due to the increase in bullying and the violence and suicides on tv. The state is actively pursuing violence prevention initiatives based on youth development. The BFH staff are participating in the design and implementation of learning supports for students in Iowa's schools.

##### Infrastructure Building Services

IDPH staff collaborated with state-level school health staff in the advocacy for effective school-based youth development prevention programs and with groups and agencies addressing related risk factors, such as substance abuse, mental health disorders, and access to lethal means of suicide. Staff members researched promising strategies and contacted states that have made progress in their youth suicide prevention efforts. IDPH continues to participate in the development of a state youth suicide prevention plan based on the Surgeon General's Call to Action. The steps in this plan are categorized as awareness, intervention, and methodology (AIM). IDPH staff members encouraged local contract agencies to engage in activities consistent with the AIM strategy. The Child Death Review Team examined records of children whose cause of death is ruled as a suicide.

##### Population-Based Services

MCH contract agencies were encouraged to integrate youth suicide prevention information into their programs. The adolescent coordinator participated in the Region VII Suicide Prevention Conference in Denver, Colorado. IDPH works to educate the public and professionals about the scope of the problem and effective prevention strategies. A brochure that includes facts about youth suicide, behavior associated with depression and suicide and intervention strategies is available on the Web and in print.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use the TEEN Line and Healthy Families Line for health information and referrals.		X		
2. Participate in the statewide Suicide Prevention Strategy Group (SPSG).				X
3. Continue to participate in the development of state youth suicide prevention plan.				X
4. Provide education and resources to local contract agencies on suicide prevention.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Infrastructure

IDPH continues to participate in the statewide Suicide Prevention Strategy Group (SPSG). The group is currently working on a proposal to establish an Office of Suicide Prevention. Legislation establishing the Office and appropriating funding to staff the office was introduced into the Iowa Legislature. If awarded funding, Title V staff will participate in project implementation.

IDPH applied for a CDC system development grant to plan for violence prevention among Iowa's youth. This planning grant was funded and implementation began on October 1, 2004.

#### Population-Based Services

The SPSG facilitated community meetings and offered suicide prevention training to interested communities. Some schools expressed interest in the use of suicide prevention rating scales. They will be encouraged to use research-based tools with proven effectiveness and assure system capacity to provide services to identified individuals.

BFH provided planning, funding and marketing for an ISU Extension broadcast focusing on what families, schools and communities can do to support healthy social and emotional development in children and youth. Two telecasts (two hours each) provided information on helping families deal with bullying and with kids who are out of control.

#### c. Plan for the Coming Year

##### Infrastructure Building Services

BFH staff will provide consultation to the CDC system development grant and assist in the completion of an adolescent suicide prevention plan that will serve as the basis for application for federal funding for depression screening of youth.

Interagency networking and collaboration with state agencies, including participation in a state agency workgroup to promote positive youth development as a means of suicide prevention will continue.

##### Population-Based Services

BFH staff will participate in planning a Governor's Conference on Bullying in Schools.

A brochure will be developed that provides youth with important facts about suicide and suicidal behavior. This will include actions to be taken when a friend tells you he is thinking of committing suicide.

**Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	80.5	63	65	70	80

Annual Indicator	64.0	67.0	64.0	87.6	95.3
Numerator	288	254	260	352	427
Denominator	450	379	406	402	448
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	96	96	96	97	97

#### Notes - 2002

Vital Statistics 2002 Provisional Data

#### Notes - 2003

Vital Statistics 2003 data. The increase in percentage is due to the increase in the number of hospitals being classified as Regional 2 level hospitals.

#### Notes - 2004

Data were obtained from Vital Statistics 2004 data. The change in percentage is due to increases in the number of hospitals being classified as Regional 2 level hospitals.

#### a. Last Year's Accomplishments

The performance objective of 65 percent was met. Of the 448 very low birth weight infants delivered in 2004, 95 percent were delivered at Level III, Level II Regional, or Level II facilities. Eighty-nine percent of very low birth weight infants were born in a Level II Regional or a Level III facility. The number of recognized Level III perinatal centers remained at three, while Level II Regional facilities were seven, and Level II facilities were 11. Eight-nine (89) hospitals provided maternity services.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue activities of the Iowa Statewide Perinatal Care Program.				X
2. Update and revise the Guidelines for Perinatal Centers for distribution to all perinatal hospitals.				X
3. Develop and maintain an email distribution list of nurse managers of all hospitals providing maternity services.				X
4. Continue to publish the Iowa Perinatal Newsletter on a quarterly basis.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Infrastructure Building Services

IDPH continued the established contract with the Iowa Statewide Perinatal Care Program. Activities included: continuation of regular meetings of the Perinatal Guidelines Advisory Committee; consultation to all Level II, Level II Regional, and Level III hospital nurseries and obstetrical departments on at least a bi-annual basis; administrative consultation to hospital and health-related groups; coordination with the High-Risk Infant Follow-up Program; on-site review of medical records, assessment of educational needs of staff and physicians, and presentation of educational programs; and evaluation of effectiveness of the Statewide Perinatal Care Program through review of preterm birth rates and location of preterm deliveries.

The "Guidelines for Perinatal Centers," published by the Perinatal Guidelines Advisory Committee on behalf of IDPH, is in the process of being updated and revised. The Guidelines are distributed to all Iowa perinatal hospitals and provide guidance on services provided by the different designated perinatal center level facilities.

#### Enabling Services

Outreach education will be provided for all healthcare staff in lower-level hospitals through tertiary hospitals by the Statewide Perinatal Care Review team.

#### Population-Based Services

During FFY05, publication of the Iowa Perinatal Newsletter continued on a quarterly basis. The annual perinatal care conference for physicians and staff of Iowa maternity hospitals was held.

### c. Plan for the Coming Year

#### Infrastructure Building Services

IDPH will continue the contract with the Iowa Statewide Perinatal Care Program. The Statewide Perinatal Guidelines Advisory Committee will also publish updated Guidelines for Perinatal Centers and ensure consistency with standards of care of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

#### Enabling Services

The Iowa Department of Public Health will continue to support strong regionalization program in Iowa. The Statewide Perinatal care team will continue education efforts to reinforce recognition of high-risk pregnancies and transfer to regional perinatal centers when appropriate.

IDPH will develop an email distribution list of nurse managers of all hospitals providing maternity services to communicate updated standards, educational opportunities, and provide networking opportunities.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	86.5	86.8	87	88	88.5

Annual Indicator	87.1	87.9	88.1	88.6	88.7
Numerator	33251	33064	33244	33809	34021
Denominator	38170	37597	37749	38139	38369
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	88.6	88.7	88.8	89	89

#### Notes - 2002

Vital Statistics 2002 Provisional Data

#### Notes - 2003

Vital Statistics 2003 Provisional data

#### Notes - 2004

Data were obtained from Vital Statistics 2004 Provisional Data.

#### a. Last Year's Accomplishments

The performance objective of 88.5 percent was met. Data for 2004 shows the percent of women entering prenatal care in the first trimester was 88.7 percent.

#### Infrastructure Building Services

In 1998, Iowa established a more specific annual objective: "By September 1998, increase the proportion of black pregnant women entering prenatal care in the first trimester from 56 percent in 1993 to 73 percent in 1998." This objective is aimed at eliminating disparities, and targets the population of pregnant black women. This objective was met in 1999, and progress continues to be positive. The rate of black women entering prenatal care by first trimester for 2004 is 76 percent.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to promote communication and collaboration between local contract maternal health agencies and local providers for maternal referral.				X
2. Provide Medicaid presumptive eligibility to pregnant women through the local Title V maternal health agencies.	X	X		
3. Assess vital records and WHIS data to determine the population in need of specific efforts.				X
4. Continue collaboration between maternal health services and WIC, child health programs, family planning services.				X
5. Continue to provide services that are comprehensive, community-based, culturally competent, and family centered through Title V.	X	X		
6.				
7.				

8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services

Local maternal health agencies identify strategies for coordinating with other community programs. Fourteen of the local contract agencies have implemented an action plan targeting prenatal care for women in their community.

##### Population-Based Services, Enabling Services, and Direct Health Care Services

Direct health care, enabling, and population-based program activities are provided by 26 local contract agencies serving all 99 counties. MCH agencies provide services to facilitate early entry into prenatal care including Medicaid presumptive eligibility determination, care coordination, case management including follow-up, and case-finding and outreach with a focus on high-risk women. IDPH also works with the Iowa Department of Human Services to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

#### c. Plan for the Coming Year

##### Infrastructure Building Services

In FFY06, data from vital records and the Women's Health Information System will be used to determine the population in need of specific efforts. IDPH staff members will continue to promote communication and collaboration between local maternal health agencies, other local agencies, and local providers for maternal referral. Integration of maternal health services with Special Supplemental Nutrition Program for WIC, child health programs, family planning services, and DHS programs will also continue. IDPH staff members will support and monitor local contract agencies' vulnerable population action plans, and will advocate for improved access to early prenatal care for undocumented (immigrant) women. All local contract agencies are required to submit an action plan targeting vulnerable populations in their communities.

##### Enabling Services

Title V funding for geographically accessible maternal health agencies will be continued. Local maternal health contract agencies will continue to provide presumptive eligibility to pregnant women and comprehensive, community-based, culturally competent, and family-centered care.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 3: *Percent of children served by Title V, excluding CSHCN, who report a medical home.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	70	75	55	60

Annual Indicator	46.0	38.8	44.6	54.9	61.1
Numerator	7820	9715	46703	64165	80535
Denominator	17000	25067	104632	116807	131787
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	70	80	85	85	

#### Notes - 2002

Data were obtained from the Child and Adolescent Reporting System (CAREs) year end report. The data are based on clients who reported a usual source of medical care that was available 24 hours a day, seven days a week, and maintains the client's record.

FFY02 data were obtained from the annual CAREs medical home report covering the entire fiscal year. FFY01 data were obtained from a proxy value from the second quarter medical home report covering January - March 2001.

#### Notes - 2003

Data were obtained from the Child and Adolescent Reporting System (CAREs) year end report. The data are based on clients who reported a usual source of medical care that was available 24 hours a day, seven days a week, and maintains the client's record.

FFY03 data were obtained from the annual CAREs medical home report covering the entire fiscal year.

#### Notes - 2004

Data were obtained from the Child and Adolescent Reporting System (CAREs) year end report. The data are based on clients who reported a usual source of medical care that was available 24 hours a day, seven days a week, and maintains the client's record.

FFY04 data were obtained from the annual CAREs medical home report covering the entire fiscal year.

#### a. Last Year's Accomplishments

The FFY04 target objective of 60 percent for this measure was met. According to the Child and Adolescent Reporting System (CAREs), Title V served 131,787 clients in FFY04 and 80,535 of them (61.1 percent) were considered to have a medical home. For this measure, a child is considered to have a medical home if:

1. the child has a usual source of medical care,
2. the source of medical care is available 24 hours a day, seven days a week, and
3. the source of medical care maintains the child's record.

#### Infrastructure Building:

The annual EPSDT Care for Kids Workshop was held in April 2004. During the workshop, local contract agencies and their subcontractors were offered breakout sessions on the importance of assisting families in establishing medical homes. In May 2004, statewide CAREs training was conducted. The training emphasized the importance of linking families with a regular medical care provider. The training also stressed the importance of documentation of medical home information in the CAREs clinical record.

#### Population-Based:

Iowa's statewide hawk-i outreach coordinator continued to assist local contract agencies in performing hawk-i outreach and enrollment activities. Outreach continued to focus on the medical community, schools, and faith-based organizations. During October 2003, Iowa's Lt. Governor traveled across Iowa to lead seven community roundtable discussions about hawk-i outreach strategies. The roundtables were attended by community representatives such as school nurses, medical providers, ministers, insurance agents, legislators, and child care providers.

Local contract agencies developed strategies to promote medical homes for pregnant women and children. Thirteen local contract agencies implemented specific action plans to address medical home issues. Some of the associated activities included:

1. educating parents about the importance of a medical home, and
2. working with area physicians to increase knowledge about Medicaid, hawk-i, and the importance of a medical home.

#### Enabling Services:

Iowa's children benefited directly from the local agency action plans directed toward medical home efforts described above. Care coordination services to children and their families resulted in an increase of 6.2 percentage points in Iowa's FFY04 indicator for SPM #3 compared to FFY03.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide TA to local contract agencies to improve coordination with local medical providers.				X
2. Conduct annual statewide CARES and EPSDT trainings to local contract agencies.				X
3. Bureau of Family Health staff will continue to serve on the IMHI Core Team.				X
4. Support local contract agencies that have implemented action plans to address medical home issues.				X
5. Share best practices and lessons learned from the IMHI (refer to NPM #3 for more information) with local contract child health agencies.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building:

Curriculum writing is underway for EPSDT training scheduled to begin in October 2005. The training will be offered on site at local contract agencies in a grassroots effort to strengthen the statewide infrastructure of child health services. The importance of the medical home is a key component of the training curriculum.

Bureau of Family Health (BFH) staff are working closely with Child Health Specialty Clinics (CHSC) staff members on the implementation of the Iowa Medical Home Initiative for CSHCN

(refer to NPM #3 for more information). Results of this project will be reviewed for recommendations to be provided to local child health agencies.

**Population-Based:**

As described previously, local contract agencies received training last year emphasizing the importance of linking families with a medical home and documenting medical home information in the CARES clinical record. Subsequently, fifteen local contract agencies implemented specific action plans for the current year to address medical home issues.

**Enabling Services:**

Iowa's children continue to benefit directly from the local agency action plans directed toward medical home efforts addressed above. Through care coordination services, children and their families are assisted to understand the importance of a medical home and to work through barriers to obtaining a medical home.

**c. Plan for the Coming Year**

**Infrastructure Building:**

EPSDT training will be provided on site at local contract agencies beginning in October 2005. The importance of the medical home is a key component of the training curriculum. Two critical issues will be emphasized to local agency staff members during the training:

- 1) the provision of care coordination to families related to medical home, and
- 2) the documentation of the child's medical home status in the Child and Adolescent Reporting System (CAREs).

Bureau of Family Health (BFH) staff will continue to work closely with Child Health Specialty Clinics (CHSC) staff members on the implementation of the Iowa Medical Home Initiative for CYSHCN (refer to NPM #3 for more information). Local child health contract agencies will benefit from this initiative as lessons learned from the CYSHCN population are translated to infrastructure recommendations for the entire child health population.

**Population-Based:**

As local child health agencies competed for FFY06 Title V funding, they submitted action plans identifying objectives they hoped to meet in the next five years. Nine local agencies developed objectives to promote medical homes for pregnant women and children in their action plans. Funded agencies will begin work on these strategies in the coming year.

**Enabling Services:**

Iowa's children will continue to benefit directly from the local agency action plans directed toward medical home efforts addressed above. Additionally, all local child health agencies will provide care coordination services to assist families to understand the importance of a medical home and to work through barriers to obtaining a medical home.

**State Performance Measure 4: *Percent of low income children ages 1-4, enrolled in child health centers who have completed a referral to a dentist.***

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>

Annual Performance Objective	20	21	22	23	6
Annual Indicator	9.0	3.0	1.5	4.5	0.9
Numerator	605	518	488	1571	354
Denominator	6725	17430	31553	35033	39063
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	5	5	6	6	

#### Notes - 2002

A proxy value was obtained from the local child health contract agencies' quarterly reports to the Oral Health Bureau.

#### Notes - 2003

Data were obtained from the Child and Adolescent Reporting System (CAREs) 2003 year end report.

#### Notes - 2004

A proxy value was used to measure SPM #4. The numerator is based on the number of children ages 1-4 using Title V dental funding for dental care as determined through quarterly dental reports. The denominator is the total number of children ages 1-4 enrolled in Title V as determined through the Child and Adolescent Reporting System (CAREs).

Because the total number of children enrolled in Title V is not limited to those eligible to use Title V funds for dental care, this objective is difficult to measure accurately. This difficulty was taken into consideration as the target was revised in FFY04.

#### a. Last Year's Accomplishments

The FFY04 performance objective of 6 percent of children ages 1-4 completing a referral to a dentist was not met. The FFY04 indicator, a proxy value, is 0.9 percent. The numerator is based on the number of children ages 1-4 using Title V dental funding for dental care as determined through quarterly dental reports. The denominator is the total number of children ages 1-4 enrolled in Title V as determined through the Child and Adolescent Reporting System (CAREs).

#### Infrastructure Building Services:

The number of agencies receiving Access to Baby and Child Dentistry (ABCD) contracts increased to 22 of 26 local child health contract agencies. The Oral Health Bureau (OHB) received funding through HRSA to improve the state and local infrastructure for oral health. The funding was used to create an ABCD Enhanced project with four local child health contractors implementing infrastructure-building activities based on ABCD best practices. Strategies included use of a Spanish interpreter and development of dental continuing education courses for local dental providers.

The OHB improved state infrastructure through increased involvement with Head Start and its oral health workgroup. The OHB provided input into the Early Care Health and Education Systems strategic plan. Oral Health Bureau staff presented information at the MCH grantee conference in October 2004, suggesting infrastructure-building activities that local grantees might incorporate into their work plans.

The OHB received technical assistance from a consultant from the Association of State and Territorial Dental Directors. The consultant provided information and tools to guide the state and local communities in activities related to oral health assessment and data analysis.

#### Enabling Services:

The OHB received quarterly reports from the Child and Adolescent Reporting System (CAREs) listing the number of dental services provided by local child health contract agencies. After analysis of the CAREs reports, staff members worked with agencies to assure that families were provided appropriate and comprehensive assistance with oral health services. Also, the OHB conducted a survey to determine the types of oral health education materials and services that state programs needed. This information was used to improve agencies' abilities to support and educate families.

#### Direct Health Care Services:

In FFY2004, all 26 local child health contract agencies used a portion of their dental funds for direct dental services. Funded services included treatments provided in dental offices and services provided by dental hygienists in child health agencies. Fifteen of the agencies employed dental hygienists to provide direct services.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase involvement with Head Start and the Early Childhood Comprehensive Systems grant to improve statewide infrastructure.				
2. Continue to allow local contract agencies to use Title V dental funds for infrastructure services, in addition to direct health care services.	X			X
3. Continue to offer ABCD funds to local contract agencies.				X
4. Continue to conduct the annual Oral Health Survey.				X
5. Provide technical assistance to local contract agencies with action plans relating to dental health.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services:

The Oral Health Bureau continues to monitor contracts and provide technical assistance for the ABCD and ABCD-Enhanced programs implemented in 21 local child health contract agencies. OHB staff participated in the National Oral Health Conference in the spring of 2005, sharing state program successes and learning about other states' program ideas, in order to strengthen state infrastructure and oral health programming. The OHB continues to participate with the Head Start Oral Health workgroup to implement action plans created at the Oral Health Summit in the spring of 2003.

The Iowa Board of Dental Examiners approved a rule change, effective in January 2004, to allow dental hygienists to perform prevention based dental services in public health settings

without onsite direct supervision by a dentist. The goal of the change was to extend the available dental workforce to increase dental care access to underserved Iowa children. The OHB is analyzing the first year of data collection since the amended rule went into effect. Portions of the data will allow assessment of services available to children under the age of five.

At Iowa's 2005 Public Health Conference, the OHB sponsored a training session describing best practices from North Carolina on working with physicians on oral assessment, fluoride varnish application, and dental referral for children under the age of 5.

In the spring of 2005 the OHB completed 12 regional meetings at locations across the state. Attendees included representatives from Title V agencies, Head Start, WIC, local boards of health, dental associations, medical associations, hospitals, and others. Preliminary feedback from participants indicates that there are five infrastructure issues:

- 1) an overall lack of providers,
- 2) a lack of providers willing to see Medicaid children,
- 3) a lack of perceived need for dental care,
- 4) a lack of transportation, and
- 5) a need for increased collaboration with physicians.

A summary report will be completed and results will be used to develop an RFP for community demonstration projects.

For the fifth consecutive year, the Iowa Department of Public Health (IDPH) completed the statewide Oral Health Survey in April 2005. With direction from the Oral Health Bureau, the survey was conducted by the state's Title V child health contract agencies. The Title V agencies screened a random sample of 1,115 third-grade children in 29 schools. The survey indicated that 43.4 percent of the children had at least one sealant on a permanent first molar.

#### Direct Health Care Services:

In FFY05, local child health contract agencies are using dental funds for direct dental services, including those provided in a dental office and those provided by dental hygienists within public health. The majority of the services provided by dental hygienists are for children served by WIC, Head Start, and Early Head Start.

### c. Plan for the Coming Year

#### Infrastructure Building Services:

Through a State Oral Health Collaborative Systems grant from HRSA, the OHB will develop an RFP to award grant funds to at least two local communities for oral health infrastructure-building projects. The OHB will continue to work with stakeholders at the state level to improve systems to assure oral health services for children. Strategies will include working with the Head Start Oral Health workgroup to implement a comprehensive statewide training program for home visitors. The training will focus on increasing the role of families in keeping children cavity-free.

The Oral Health Bureau will collaborate with Iowa's Early Childhood Comprehensive Systems project in a public awareness campaign focused on health issues for young children. OHB will assist local child health agencies to encourage community physicians to provide oral assessments for children and make appropriate referrals to dental offices.

#### Enabling Services and Direct Health Care Services:

The OHB will continue to receive quarterly reports from the Child and Adolescent Reporting System (CAREs) listing the number of dental services provided by local child health contract agencies. Staff members will format these reports for readability and distribute them to the local agencies. Local agencies will be encouraged to seek technical assistance to maximize use of

the reports to track enabling services provided to children and families.

Local child health agencies will provide care coordination services, oral screenings, and dental referrals for their clients. Outreach activities will continue through the ABCD project, which will be implemented in all child health agencies in the coming year.

**State Performance Measure 8:** *The degree to which key data are collected, managed, analyzed, and utilized for strategic assessment of the determinants and consequences of the health status of women, children, and families.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	44	64	67	70
Annual Indicator		61	66	70	72
Numerator		61	66	70	72
Denominator	96	96	96	96	96
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	73	74	75	76	

#### Notes - 2002

The data were obtained from a checklist of components that documents data system development. The checklist indicates the degree to which Iowa's Title V data systems have been developed.

#### Notes - 2003

The data were obtained from a checklist of components that documents data system development. The checklist indicates the degree to which Iowa's Title V data systems have been developed.

#### Notes - 2004

The 2004 data were obtained from a checklist of components that documents data system development. The checklist indicates the degree to which Iowa's Title V data systems have been developed.

#### a. Last Year's Accomplishments

Iowa has demonstrated steady improvement in statewide MCH data infrastructure in recent years. The FFY04 performance objective of 70 points was met. A score of 72 points was achieved on the rating scale in FFY04, up from 70 points in FFY03. The Checklist for Data System Development is attached to this narrative. The checklist displays the components of the scoring by MCH population.

#### Infrastructure Building Services:

During FFY04, analysis of the 2000 Iowa Child and Family Household Health Survey was completed and the final report, Health Insurance Coverage of Children in Iowa, was published. Four previously published reports resulted from analysis of the 2000 Iowa Child and Family Household Health Survey. These reports focused on statewide results, regional results, children with special health care needs, and racial/ethnic disparities. The reports are available at the survey website: <http://ppc.uiowa.edu/health/iowachild2000/index.html>.

The MCH Data Integration Steering Committee and the MCH Data Integration Team met quarterly in FFY04. Both groups demonstrated positive results related to increased knowledge of individual members and strengthening of the MCH data infrastructure.

The Data Subcommittee of the MCH Grantee Committee met for to discuss issues related to the statewide data reporting systems. Group members from local contract agencies provided insightful feedback to state program staff throughout the year. The Data Subcommittee recommendations were incorporated into the upgrade of the Women's Health Information System (WHIS). The committee developed user reports for the Child and Adolescent Reporting System (CAREs). The distribution plan for these reports included a quick turnaround to local contract agencies each quarter.

Two Iowa teams, totaling seven individuals from local MCH entities, participated in the University of Nebraska Data Use Academy (DUA) during FFY04. The focus of the DUA training was to increase the data skills and capacity of the team members. As part of the training, the two teams initiated research projects focusing on substance abuse prevention among middle school students and improvement of the health and well being of families with children ages zero to five.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the MCH Data Integration Steering Committee and the MCH Data Integration Team.				X
2. Continue to convene the MCH Grantee subcommittee to provide input for improvements in statewide data systems.				X
3. Implement the 2005 Iowa Child and Family Household Health Survey.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

#### Infrastructure Building Services:

In FFY05, local and state stakeholders have evaluated the design and methodology of the 2000 Iowa Child and Family Household Health Survey (HHS) in preparation for re-survey in September 2005.

The MCH Data Integration Team and the Data Integration Steering Committee continue to meet quarterly in FFY05. These groups strengthen the capacity of Iowa's data workforce through continued emphasis on data integration concepts.

In FFY05, the Data Subcommittee of the MCH Grantee Committee continued to involve the local users in activities to improve the statewide data systems. Subcommittee members from local contract agencies actively partnered with state staff to focus on universal definitions of data entry elements and quality assurance within the electronic clinical record.

Iowa's ability to utilize MCH data received a boost in FFY05 with the assignment of an MCH epidemiologist from the Centers of Disease Control and Prevention. Dr. Debra Kane began her duties in Iowa in January, 2005. Her responsibilities have been carefully determined to coincide with Title V needs and SSDI objectives.

### c. Plan for the Coming Year

#### Infrastructure Building Services:

At the beginning of FFY06, implementation of the 2005 Iowa Child and Family Household Health Survey (HHS) will be completed and initial analysis will begin. Quarterly meetings of the MCH Data Integration Steering Committee and the MCH Data Integration Team will continue. The Data Subcommittee of the MCH Grantee Committee will continue to involve the local users of the MCH data systems in planning improvements in the statewide systems.

### State Performance Measure 11: *Percent of counties that report screenings and referrals for behavioral problems in young children (ages 3-5).*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	10	65	68	69
Annual Indicator	56.6	63.6	63.6	55.4	53.5
Numerator	56	63	63	51	53
Denominator	99	99	99	92	99
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	70	70	70	72	

#### Notes - 2002

A survey was conducted with local public health nurses to identify the number of screenings and referrals for children ages 3-5 at the county level. The survey is repeated every year.

#### Notes - 2003

A survey was conducted with local public health nurses to identify the number of screenings and referrals for children ages 3-5 at the county level. There were 92 out of the 99 counties that replied to the survey. Fifty-one out of 92 are providing screenings and referrals for children ages 3-5.

#### **Notes - 2004**

A survey was conducted with local public health nurses to identify the number of screenings and referrals for children ages 3-5 at the county level. There were 97 out of the 99 counties that replied to the survey. Fifty-four out of 97 are providing screenings and referrals for children ages 3-5.

#### **a. Last Year's Accomplishments**

Each year, a needs assessment is conducted related to mental / behavioral health problems in young children in Iowa. The needs assessment methodology includes a survey of county public health administrators requesting information about screening, referral, access, and quality of services in the area. In the summer of 2004, the survey of public health administrators revealed that 53.5 percent of the agencies made referrals for mental / behavioral services for children between the ages of three and five. The FFY04 performance objective of 69 was not met.

#### **Infrastructure Building Services:**

In 2003, IDPH collaborated with DHS, the state's Medicaid agency, in obtaining funding for the Assuring Better Child Health and Development (ABCD II) project through the Commonwealth Fund. The project began in January 2004 and will conclude in December 2006. A Healthy Mental Development Panel was convened to make recommendations regarding screening levels, tools for use at the different stages of the early identification system, the use of the Iowa Health Maintenance Clinical Notes Forms, and the referral processes for private and public providers.

The Creston Behavioral Health Program (CBHP) piloted the provision of intensive care coordination to children with behavioral health needs. Through funding from Magellan Behavioral Health, web cameras were purchased for telepsychiatry, physician consultation, family counseling, and interpretation services. The telehealth strategies were used to provide services to children, including those between the ages 3 and 5. The CBHP pilot project concluded in November 2004. Preliminary data analysis from the Child and Adolescent Needs and Strengths (CANS) assessment tool showed that children who received intensive care coordination as compared to children who received usual care (i.e. less intensive care coordination) showed greater improvement in functioning and strengths. Children who received intensive care coordination also utilized, on average, fewer mental health services over the course of participation in CHSC's Integrated and Evaluation and Planning Clinics. Preliminary analysis suggests significant financial savings for families participating in the CBHP. Further data analysis is underway. Magellan Behavioral Health granted funds to CHSC to plan and implement an expanded statewide telepsychiatry and intensive care coordination service based on the CBHP model.

CHSC also received a DHS Wraparound Grant focused on meeting the needs of children with Serious Emotional Disturbance (SED). The seven-month grant ended in September 2004. The project successfully completed activities that increased the behavioral and mental health service infrastructure for Union, Adams and Adair counties. Although CHSC is no longer involved in the local effort, community partners obtained a grant to extend and expand the project.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Update and maintain the EPSDT Care for Kids web site.				X
2. Continue to monitor the CHSC mental health services in Creston and Ottumwa.				X
3. Continue implementation of the ABCD II project.				X
4. Continue to provide telepsychiatry to children between the ages of 3 and 5. (CHSC)	X			
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services:

Data from the Creston Behavioral Health Program (CBHP) pilot is being analyzed for the effects of intensive care coordination to children with behavioral health needs and their families. The data analysis and interpretation will be used to modify Child Health Specialty Clinics protocols for Integrated Evaluation and Planning Clinic.

Child Health Specialty Clinics (CHSC) received funds from Magellan Behavioral Health to allow it to continue to use web cameras for telepsychiatry, physician consultations, family counseling, and translation services. Staff will use telehealth to provide these services to children between the ages of three and five. CHSC will hire five 0.5 FTE staff nurses to be housed at the regional centers. A 0.5 FTE advanced nurse practitioner will be hired to oversee the program, assist in the development of care protocols for behavioral and mental health diagnoses, and triage children discharged from inpatient psychiatric units to CHSC regional centers for follow-up care.

Activities continue on the Assuring Better Child Health and Development (ABCD II) project funded through the Commonwealth Fund. The ABCD II project plan for the current year involves working closely with two demonstration sites. The sites have been chosen and community partnerships have been formed. One demonstration site will serve children in an urban pediatric office and the surrounding local MCH region. The second demonstration site will serve children in a rural family practice office and the corresponding local MCH region. Consultants from the National Academy for State Health Policy (NASHP) and the Commonwealth Fund conducted a site visit in Iowa in June 2005. The consultants visited the rural demonstration site and met with representatives of the urban site at the IDPH offices. Results from the demonstration sites will be used to generate guidance on referral and intervention strategies. The guidance will be shared with physician practices, the Title V child health grantees, and other community partners.

The EPSDT Care for Kids web site was revised and enhanced in June 2005. The web site is a significant resource for Medicaid providers and includes important information regarding behavioral health care for children.

In FFY05, the annual public administrators survey indicated that 55.7 percent made referrals for behavioral / mental health issues for children age 3 to 5. This indicator value does not meet the FFY05 performance objective of 70.

##### Direct Health Care Services:

Child Health Specialty Clinics continues to provide telepsychiatry to children between the ages of three and five.

### c. Plan for the Coming Year

#### Infrastructure Building Services:

CHSC will continue to provide telepsychiatry and consultations with physicians via web cameras. Additional care protocols for behavioral and mental health diagnoses will be developed. Additional mental and behavioral health trainings for community providers will be conducted.

ABCD II project activities will continue in the coming year with an emphasis on the two demonstration sites. Promising practices developed and tested at the sites will be evaluated for replication in additional communities. Models will be created with flexibility to allow communities to adapt them to their needs. Informational articles will be submitted to newsletters and other media regarding lessons learned at the demonstration sites. The project is expected to:

- 1) establish minimum standards for screening and referral,
- 2) recommend best practice tools and educational materials,
- 3) identify effective service models, and
- 4) create Medicaid policies to facilitate access to needed care.

### State Performance Measure 13: *Percent of infants determined to be at-risk receiving monitoring and follow-up services at age 12 months.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	0	10	25	50	55
Annual Indicator	4.4	5.3	6.9	7.4	9.2
Numerator	195	240	310	323	420
Denominator	4480	4561	4479	4360	4579
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	60.5	66.5	73.1		

#### Notes - 2002

Annual performance objectives for 2004-2007 were changed based on improved understanding of the systemic complexities related to fulfilling Part C's role as a statewide resource and database for at-risk young children. The current method to determine the denominator for this performance measure may change pending a review of the agreed upon incidence rate of infants assumed to be at-risk for future developmental delay. The review will occur at the end of ffy03 and will influence the method for calculating the ffy03 annual indicator value.

### Notes - 2003

Because the Part C database only tracks developmentally delayed infants and not at-risk infants, the indicator value for this performance measure remains substantially lower than the target objective. The Iowa Title V Programs support improved data capacity to track at-risk infants. A new performance measure and/or new data source will be chosen should the related state priority need be reconfirmed by the upcoming 5-year needs assessment.

### Notes - 2004

Because the Part C database only tracks developmentally delayed infants and not at-risk infants, the indicator value for this performance measure remains substantially lower than the target objective. The Iowa Title V Programs support improved data capacity to track at-risk infants. Ideally, a centralized statewide at-risk database will be created, however, much discussion, planning, and organization must occur before this becomes reality.

#### a. Last Year's Accomplishments

The FFY04 performance objective of 55.0 percent for this measure was not met (FFY04 indicator value = 9.2 percent).

It must be noted that this performance measure is concerned with the at-risk infant population. Unfortunately, the data from Iowa's Part C Program used to calculate the indicator value reflects infants already determined to be developmentally delayed. Thus, the performance indicator numerator (age-specific Part C enrollment count) is disproportionately small relative to the performance indicator denominator (estimated total number of at-risk infants). Because the Iowa Part C database currently only tracks developmentally delayed infants and not all at-risk infants, Iowa, unfortunately, continues to be unable to offer a more relevant indicator measure for this state priority.

#### Infrastructure Building Services:

Child Health Specialty Clinics (CHSC) and IDPH continued close collaboration with Iowa's Part C Program (Early ACCESS) to improve the early intervention system for children 0-3. Special emphasis was placed on developing procedures by which CHSC could perform and document the responsibilities of service coordination for Early ACCESS enrollees.

Early ACCESS continued a contract with CHSC's Iowa Medical Home Initiative to improve the performance of primary care physicians regarding early identification and referral. In a related activity, CHSC and IDPH staff participated as planners and advisors in an Iowa Department of Human Services grant project to improve developmental screening and early intervention services in primary care practice offices. Activities of the project, called Assuring Better Child Health and Development (ABCD II), are coordinated by IDPH staff.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Part C to develop performance indicators to monitor early intervention services.				X
2. Use the Iowa Medical Home Initiative as a vehicle to spread system improvements regarding primary care physician performance in developmental screening and referral.				X
3. Integrate CHSC's Birth to Five Program and Iowa's Part C Program to improve tracking and follow-up for at-risk infants/toddlers.				X
4. Collaborate with and support the Assuring Better Child Health and				

Development (ABCD II) project in its review and recommendations of developmental screening instruments and standards for early childhood developmental screening and intervention.				X
5. Collaborate with the Iowa Early Childhood Comprehensive Systems project to improve Iowa's system of early care and education.				X
6. Serve, when requested, on any advisory committee to develop a Part C data system or other statewide database capable of tracking at-risk children, 0-3.				X
7.				
8.				
9.				
10.				

## b. Current Activities

### Infrastructure Building Services:

In FFY05, CHSC continued to partner with Early ACCESS, refine its own Birth to Five Program, and participate in new early childhood projects. Specific IDPH projects included the Early Childhood Comprehensive Systems project (funded by the federal MCHB) and the Assuring Better Child Health and Development project (funded by The Commonwealth Fund).

The Iowa Medical Home Initiative continues as a resource to early childhood system development efforts through promotion of developmental screening and early intervention services by primary care practices.

The Regional Autism Services Program, based at CHSC and funded by the Iowa Department of Education, contributed to the construction of a developmental screening form that will be capable of improving early detection of autism spectrum disorders.

In April 2005, CHSC was awarded a new MCHB grant to improve detection of early hearing loss and provide early intervention. The CHSC director will be the director for the project and a 0.8 FTE program assistant will be hired to coordinate the project.

In July 2005, the Bureau of Family Health entered into a three-year cooperative agreement with the Centers for Disease Control and Prevention. The purpose of the cooperative agreement is to improve the state's system for Early Hearing Detection and Intervention (EHDI) surveillance.

## c. Plan for the Coming Year

### Infrastructure Building Services:

In FFY06, IDPH and CHSC expect to continue partnering with the Part C Program. CHSC expects to formalize its role as a follow-up resource for young children, 0-3, who are at-risk, but ineligible for Part C early intervention services.

The CHSC Birth to Five Program will begin involvement in a planned multiyear quality assurance effort focusing on professional competencies. The Birth to Five Program will also position itself as a potential statewide follow-up resource for children, 0-3, who are determined to be at-risk for developmental delay, but not eligible for Part C early intervention services.

IDPH and CHSC will maintain representation on the Early ACCESS Data Development Technical Advisory Committee in the hope that Early ACCESS will ultimately develop and oversee the database for an integrated, comprehensive, and efficient statewide early childhood care system.

This particular State Performance Measure will not be continued as part of the next five-year Title V planning cycle; however early childhood health and development priorities will be represented in new and related State Performance Measures.

State Performance Measure 14: *Ratio of black-to-white preterm births.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2.1	1.8	1.5	1.2	1.0
Annual Indicator	2.4	2.3	1.1	1.4	1.6
Numerator	104.4	138.1	105	126	107
Denominator	44.1	61.1	95.1	92	68
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	1.0	1	1	1	

**Notes - 2002**

Vital Statistics 2002 Provisional Data  
 Numerator - Rate of Black preterm births  
 Denominator - Rate of White preterm births

Preterm - less than 37 week gestation.

**Notes - 2003**

Vital Statistics 2003 Provisional Data  
 Numerator - Rate of Black preterm births  
 Denominator - Rate of White preterm births

Preterm - less than 37 week gestation.

**Notes - 2004**

Vital Statistics 2004 Provisional Data  
 Numerator - Rate of Black preterm births  
 Denominator - Rate of White preterm births

Preterm - less than 37 week gestation.

**a. Last Year's Accomplishments**

Provisional 2004 data indicate that this performance objective of 1.0 was not met. The black-to-white preterm birth ratio in 2004 was 1.6. This indicator measures Iowa's ability to reduce the ratio of black-to-white preterm births to no more than 1.0 (indicating no disparity.) Preterm birth is defined as live birth at less than 37 weeks gestation. The numerator indicates a rate of 109

black preterm live births per 1000 black live births in 2004. The denominator indicates a rate of 68 white preterm live births per 1000 white live births in 2004.

#### Infrastructure Building Services:

Educational presentations were made to obstetrical and neonatal health care providers across the state. Materials from the March of Dimes were utilized to present information on the possible causes and prevention of preterm births. Meetings were held with African American community leaders to discuss possible venues for the provision of infant mortality and health promotion education to African Americans.

The state's Child Death Review Team reviewed infant death records, analyzed data, examined trends, and provided recommendations for program planning. Work with the March of Dimes Premature Birth Prevention campaign continued. Iowa's Repetitive Preterm Birth Prevention Project provided evaluation to women with previous miscarriage or extreme premature birth. The program specifically targeted Medicaid women.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collaborate with the March of Dimes to advocate for prematurity prevention activities.				X
2. Collaborate with the state's Child Death Review Team to review infant death records and provide recommendations for program planning.				X
3. Continue to collaborate with the IDPH Office of Minority Health.				X
4. Support and monitor local contract agencies' action plans relating to vulnerable populations.				X
5. Use WHIS data to monitor monthly outreach activities of the local contract agencies.				X
6. Collaborate with the Iowa's Healthy Start Program to provide prenatal services for minority and low-income populations.			X	
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services:

Earlier this year, Iowa's Statewide Perinatal Care Team met with leaders in the African American community in Polk County to address the discrepancy in infant mortality rates. The community leaders developed a video that outlines activities families can take to help prevent infant deaths. The video was provided to Polk County faith-based organizations that have large African American memberships.

##### Population-Based Services:

Iowa's Healthy Start Program, located in Polk County, provides prenatal services for minority and low-income populations in select areas of high infant mortality.

##### Enabling Services:

In programming prenatal services for pregnant women, Bureau of Family Health staff and the

26 local contract agencies address case finding and outreach to minorities and hard-to-reach populations. Local contract agencies specifically target minority populations in their annual action plans. IDPH works with the Iowa Department of Human Services to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

### c. Plan for the Coming Year

#### Infrastructure Building Services:

The Women's Health Information System (WHIS) will monitor the effectiveness of minority outreach activities of the local contract agencies. The WHIS system will monitor the provision of prenatal services, including enhanced services, to minority populations. The BFH Women's Health (WH) Team will examine factors that put women at risk for preterm delivery such as substance abuse, smoking, high blood pressure, and infection. The WH Team will work with the IDPH Office of Minority Health and representatives of minority populations to reduce preterm birth rates. IDPH will collaborate with the Department of Human Services to promote enhanced services for pregnant women. Local contract agencies will again be encouraged to provide targeted outreach to minority populations. Collaboration will continue with the March of Dimes to advocate for prematurity prevention activities. The Bureau of Family Health will partner with the IDPH Division of Tobacco Control and Cessation to promote and support smoking cessation for pregnant women.

In the coming year, the video developed by the African American leadership in Polk County will be promoted and provided to stakeholders throughout Iowa.

### State Performance Measure 15: *Percent of WIC clients, ages 2-5 years, that are overweight at or above the 95th percentile as defined by PedNSS.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.1	8.1	8.0	7.9	9
Annual Indicator	9.5	10.5	10.1	10.3	11.0
Numerator	3850	4209	4387	4546	4992
Denominator	40536	40086	43595	44137	45382
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	9	8.8	8.6	8.6	

#### Notes - 2002

Data were obtained from the Pediatric Nutrition Surveillance System (PedNSS).

## **Notes - 2003**

Data were obtained from the Pediatric Nutrition Surveillance System (PedNSS).

## **Notes - 2004**

Data were obtained from the Pediatric Nutrition Surveillance System (PedNSS).

### **a. Last Year's Accomplishments**

The FFY04 target objective of 9 percent for this measure was not met. The prevalence of overweight (weight/height >95th percentile) in children ages 2-5 years was 11 percent as reported by the Pediatric Nutrition Surveillance System (PedNSS). Iowa PedNSS data reflects nationwide trends of increasing prevalence of overweight among children. The increase has been attributed to a food environment that encourages selection of foods high in fat and sugar with limited access to healthy foods, changes in family functioning surrounding meal preparation and serving, increased television and screen time and the introduction of technological advances that decrease physical activity in activities of daily living. While increases in the prevalence of overweight have been observed in all socio-economic classes, Iowa's low income population, which is served by the WIC program, may be at greater risk. Iowa is considering social reinforcement of healthy lifestyles through the Physical Activity and Nutrition grant from the Centers for Disease Control and Prevention.

#### **Infrastructure Building Services:**

Increases in childhood obesity in the WIC population parallel nationwide trends in children of all ages. Tracking of overweight children in the Special Supplemental Nutrition program for WIC continues via the PedNSS. The Youth Risk Behavior Survey (YRBS) tracks BMI based on self reported height and weight as well as diet and physical activity of high school aged youth.

In 2004, IDPH obtained funding through a five-year CDC cooperative agreement called Nutrition and Physical Activity to Prevent Obesity and Other Chronic Diseases. The new planning grant allowed the IDPH Bureau of Nutrition to target obesity-related issues beyond food intake. Physical activity became a major area of interest for the bureau. The renamed Bureau of Nutrition and Health Promotion hired three full-time staff members to plan and coordinate project activities.

Staff members from the IDPH Bureau of Nutrition and Health Promotion continued to participate in the Iowa Partners for Healthy Kids which brought together representatives from state-wide organizations to promote healthy environments in Iowa's schools. IDPH staff members also participated in planning a pilot obesity prevention intervention in physicians' offices. The intervention was supported through a Wellmark Foundation grant to the Iowa Medical Society and targeted children ages 0-5.

#### **Population-Based Services:**

Staff members of the Iowa WIC Program attended train-the-trainer sessions on nutrition and physical activity at the annual WIC Conference in September 2004 and through follow-up distance learning sessions. The training modules were developed by the Pennsylvania WIC Program and includes topics such as:

- 1) increasing physical activity,
- 2) reducing television time,
- 3) reducing fast food and snacking,
- 4) developing positive attitudes towards food,
- 5) limiting juice intake,
- 6) reducing fat, and
- 7) increasing fruits and vegetables.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to participate in the Iowa Partners for Healthy Kids project to promote healthy environments in Iowa's schools.				X
2. Develop guidelines for WIC staff to address obesity issues.				X
3. Provide technical assistance to local contract agencies with action plans related to childhood obesity.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure Building Services:

Obesity prevention activities funded by the CDC cooperative agreement described above continued into FFY05. The project, named Iowans Fit for Life, focuses on nutrition and physical activity to prevent obesity and other chronic diseases. Oversight of activities was assumed by an interagency task force. Community forums were held in seven Iowa locations to gather input from local partners. All Iowa WIC agencies conducted local community forums to gather input for the state plan.

Each year the IDPH Oral Health Bureau (OHB) conducts a dental sealant survey in Iowa schools. In March 2005, the IDPH Bureau of Nutrition and Health Promotion partnered with the OHB to include collection of height and weight data as part of the sealant survey.

A distributed list serv that provides nutrition and physical activity information to professionals across Iowa continues to receive positive feedback.

##### Population-Based Services:

Go the Distance, a competition that encourages Iowa youth to develop healthy activity and eating habits, was conducted for the second year from January to May 2005. 5,839 Iowa youth, in 312 Go the Distance teams, accumulated 2,103,896 miles of activity during the competition. On May 11, 2005, 24,574 students in 85 Iowa schools participated in the second Go the Distance Day.

In February 2005, each of the 99 Iowa counties submitted a Community Health Needs Assessment Health Improvement Plan (CHNA & HIP) to the Iowa Department of Public Health. There were 76 counties identified goals related to obesity as part of the CHNA & HIP process.

#### c. Plan for the Coming Year

##### Infrastructure Building Services:

In FFY06, partners from across Iowa will contribute to the CDC funded obesity prevention project. Six work groups will be formed: child care, educational settings, business and agriculture, older Iowans, health care, and community. A data and epidemiology committee will work closely with the six work groups to determine existing sources of data and data needs. The prevalence of overweight children will continue to be tracked through the Pediatric Nutrition

Surveillance System and the Youth Risk Behavior Survey. An advisory group will work with the six work groups to write a state plan for the promotion of nutrition and physical activity.

Successful community applicants for Iowa's Harkin Wellness Grants will begin project activities in September 2005. Community partners will plan, implement, evaluate, and institutionalize established or innovative strategies. The strategies will contribute directly to the prevention, delay and/or mitigation of preventable premature chronic disease. The activities will address protective factors such as good nutrition, increased physical activity, reduced tobacco use, and promotion of positive mental well-being.

**Population--Based Services:**

Staff at local WIC agencies will continue studying and implementing the eight nutrition and physical activity modules developed in Pennsylvania. IDPH staff will work with the Iowa Medical Society as the pilot intervention in physician's offices is evaluated and further plans are developed. Progress on the CDC funded obesity prevention project will be posted on a web site to gather input from Iowans.

A school-based intervention will be implemented in the 2005-2006 school year using the Pick a Better Snack and Act curriculum developed in Iowa.

As described above, 76 of the 99 counties in Iowa identified goals related to obesity as part of the CHNA & HIP process. In the coming year activities will begin in each of these 76 counties as they strive to meet these community-level goals.

**State Performance Measure 16: *Percent of families of 1 year old children enrolled in WIC who have participated in parenting education.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	15	20	20	15	17
Annual Indicator	15.0	15.2	14.2	14.8	14.4
Numerator	9180	477	125	1080	1261
Denominator	61197	3142	880	7300	8740
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	20	22	24	26	

**Notes - 2002**

Data were obtained from the WIC parent education survey. A standard definition of parent education has been developed by BFH staff and shared with WIC staff and clients.

Only infants receiving their one year WIC visit were reported for the 2002 data. 2001 data reported infants receiving their one year and eighteen month visit.

### Notes - 2003

Data were obtained from the WIC parent education survey. A standard definition of parent education has been developed by BFH staff and shared with WIC staff and clients.

Only infants receiving their one year WIC visit were reported for the 2003 data.

### Notes - 2004

Data were obtained from the WIC parent education survey. A standard definition of parent education has been developed by BFH staff and shared with WIC staff and clients.

Only infants receiving their one year WIC visit were reported for the 2004 data.

#### a. Last Year's Accomplishments

The performance objective of 17 percent was not met. The percent of parents of one-year-old children who attended a parent education class was 14.4 percent. An additional 3.9 percent of the parents were interested in receiving information about available parent education classes.

#### Infrastructure Building Services:

Through the Early Childhood Comprehensive Systems Project, IDPH staff, the Early Childhood Iowa Stakeholders group, and the Quality Services and Programs (QSP) component work group focused on parenting education and family support. The QSP component work group collected national and state-level definitions of family support and parent education programs. This group then combined several definitions and presented it to the Family Leadership Group. Follow-up on the Family Leadership Group activities is referenced in the current activities.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop criteria for evidenced based family support and parenting education programs.				X
2. Continue to convene the Family Support Leadership Group.				X
3. Develop a list serve for the Family Support Leadership group and other family support organizations.				X
4. Conduct technical assistance trainings on evidenced based criteria for early childhood organizations.	X			
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

#### Infrastructure Building:

In December 2004, the Quality Services and Programs (QSP) component work group brought together a Family Leadership group to help define a common terminology for family support in Iowa. The Leadership group consisted of state level managers, local level managers and direct

service providers of family support and parent education programs across Iowa. More than 75 people attended the meeting. The group developed future activities for the QSP component work group related to family support and parent education. Iowa's family support definition is attached to this performance measure. The Family Support Leadership group will have a strong role as a statewide network for family support and parent education programs.

The QSP component work group is developing elements that family support and parent education programs can use to assess and evaluate their programs. These elements will help assess if a program is evidenced based and a quality program for children and families. These elements will also be disseminated and used by local maternal and child health agencies and local Community Empowerment Areas. The State Empowerment Technical Assistance Team will use these elements in their technical assistance trainings with local Community Empowerment Areas. In August and September, the State Empowerment Team will conduct a regional training on Child and Family Assessment and Evaluations. The elements of quality family support and parent education will be rolled out at the trainings.

### c. Plan for the Coming Year

#### Infrastructure Building:

This specific performance measure has been eliminated due to data availability. It was clear from the needs assessment and prioritization that family support and parent education was a need in Iowa. A new performance measure will look at the Community Empowerment Areas that fund family support and parenting education programs. This should address data availability issues. The new performance measure is: "Percent of Community Empowerment funded family support programs identified as evidence-based practices."

The Iowa Department of Public Health and the Early Childhood Iowa Stakeholders have applied for the competitive Early Childhood Comprehensive Systems enhancement grant. Iowa's grant application focuses on training and technical assistance of organizations that offer providers family support and parenting education certification. We will focus on defining a common training and technical assistance curriculum for these organizations.

## E. OTHER PROGRAM ACTIVITIES

### Other (MCH) Capacity

The MCH Title V program has been extensively involved in providing leadership for changes in the service delivery system for children including but not limited to Community Empowerment Areas, the State Children's Health Insurance Program, Early Hearing Detection and Intervention, Newborn Metabolic Screening, Early ACCESS (IDEA, Part C), and the Iowa Medical Home Initiative. A list of formal and informal organizational relationships is located in the attachment for Organizational Structure section IIIC.

Family Planning activities are coordinated with the IDPH Family Planning Program and the Family Planning Council of Iowa, the Title X contractor for the state.

Following are other CHSC program activities:

1. State and regional staff are involved with planning and operation of Community Empowerment Areas.
2. Staff contribute to course development and teaching for the University of Iowa College of Public Health MCH focus track students and other graduate students.

3. Staff participate in planning and providing experiences for leadership training in the ILEND (Iowa Leadership Education in Neurodevelopmental Disorders) program. The CHSC Director is the co-director of the ILEND grant.
4. CHSC, when requested, works with the Iowa Departments of Human Services and Public Health to assure quality care for CYSHCN enrolled in Medicaid and SCHIP Programs.
5. Staff participate in planning and field-testing new approaches to delivering physical and behavioral health care services and consultation to community-based sites using telemedicine techniques.
6. Staff lead and participate in constructing and implementing the long-range statewide public health blueprint, "Healthy Iowans 2010", which is modeled after "Healthy People 2010".
7. CHSC is represented on the College of Public Health "Community Health Partners Advisory Committee" that seeks to provide training and field experiences to new public health professionals.
8. Staff direct a SPRANS grant project to integrate systems for CYSHCN with emphasis on the medical home, care coordination for primary care practices, and early childhood screening.
9. Staff lead an MCHB-supported project to improve the statewide system of early hearing detection and intervention for newborns and infants.
10. Staff participate in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.
11. Staff participate in a Department of Human Services effort to assure healthy child mental development by improving early childhood screening practices among primary care providers.
12. Staff participate in several Part C program planning and quality assurance activities.
13. Staff serve on a Governor appointed multidisciplinary collaborative work group to develop a statewide system of mental health services for children.
14. Staff serve in an advisory capacity to the Department of Public Health data integration initiative.

## **F. TECHNICAL ASSISTANCE**

The Bureau of Family Health is requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2006 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis of the early childhood section. This technical assistance will help the Early Care, Health, and Education System with population based data for four of the system indicators in Iowa's Early Childhood Iowa Strategic Plan.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a plenary speaker at the 2006 Public Health Conference. The plenary session will focus on capacity building within the public health system. The annual Public Health Conference will be held March 28-29, 2006 in Ames, Iowa.

BFH is also requesting technical assistance for a peer to peer site visit for supporting SSDI objective to obtain expertise in data integration from another state health department. IDPH is also requesting peer to peer visit to look at best practices from other states that use a competitive bid process for local Maternal and Child health contracts.

Child Health Specialty Clinics is requesting technical assistance to support consultation with the MCHB Center for Evidence-Based Practice. In keeping with its core public health responsibilities,

CHSC directs a significant portion of its resources to system development projects and initiatives - for example, the Iowa Medical Home Initiative and a pediatric behavioral health access improvement project. Although we realize the importance of data - descriptive and analytic; qualitative and quantitative - for effective program operation, rational program planning, and influential policy development, we need case-based technical assistance to help us maximize impact of our system development efforts. We believe a technical assistance consultation will increase the probability of successful implementation and spread of our system improvement initiatives.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

See Forms, 3, 4, and 5

Form 3, State MCH Funding Profile, shows a federal allocation expenditure of \$7,371,735. With the exception of infant health category, budget and expenditures varied by less than eight percent. The infant health expenditures varied from budget by 37 percent. This is due to changes in the contract for services for neonatology consultation, which was decreased from \$55,000 to \$15,500. In addition, the proportion of infants served by local Child Health agencies were less than expected. In both instances, this additional amount was expended in the child health category. Contracts with CHSC for MCH Block Grant funds are written for two-year contract periods. Consequently, federal funds not expended in year one of this contract do not meet the DPH Fiscal Bureau's definition of unobligated funds. Therefore, they are not included in the reported unobligated balance.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2004 in the amount of \$15,782,119. Of this amount, \$8,488,083 was funded by federal Title V. The state match is reported at \$5,225,941. This exceeds both the state match requirement and the maintenance of effort requirement. Federal Title V funds expended for infant and child health primary and preventive care was \$3,235,323 or 38 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at \$2,984,475 or 35 percent of the federal block grant funds expended for the year. Administration expenditures of \$391,678 represent four percent of the federal Title V amount.

Expenditures for FFY04 exceed Block Grant budgeted amounts. This can be attributed to a decrease in state funds appropriated by the General Assembly. Other variances are explained by efforts to maximize the use of other funding sources and recognize Title V as the payor of last resort. In the attachment, Figure 1 depicts the distribution of federal Title V expenditures by types of individuals served.

In the attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows a continual gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state.

### **B. BUDGET**

The FFY06 Title V appropriation is projected to be \$6,737,839 and a unobligated amount of \$830,778 for a total of \$7,568,617. As itemized in the attachment, this expected allocation is budgeted as follows: \$1,704,248 (23%) for maternal health services; \$249,609 (3%) for infant health services; \$2,664,646 (35%) for child health services; \$2,420,591 (32%) for services to children with special health care needs; and \$529,523 (7%) for program administration. These budgeted amounts include unobligated amounts that will be expended in FFY06. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. In the attachment, Figure 5 illustrates the budget plan for the FFY06 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

Completion of Budget Forms

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is \$5,164,902. Iowa continues to exceed the state maintenance of effort of \$5,035,775, required since 1989.

Iowa strives to maintain an unobligated balance of approximately \$650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, unobligated funds may be used on an as-needed basis to prevent an interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be \$14,755,495. This figure, as well as the following breakout by level of services, includes a projected unobligated balance of \$830,778 from FFY05. In the attachment, Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service as well as population group served.

#### Direct Services.

The federal-state partnership expenditures for continuation of direct care services are estimated at \$3,971,482. This represents approximately 27 percent of the partnership budget. The amount includes 16 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of \$1,615,013 or approximately 32 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

#### Enabling Services.

The federal-state partnership expenditures for continuation of enabling services are estimated at \$4,145,766 representing 28 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. It also includes 100% of child health local funds and 56 percent of the funding for local maternal health. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

#### Population Based Services.

The federal-state partnership expenditures for continuation of population-based services are estimated at \$1,731,221, which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 22 percent of the funding for local child health agencies and 10 percent of local maternal health funds. IDPH projects expenditure of \$1,412,639 (plus the related administrative costs of \$95,314), and CHSC projects a budget of \$223,267 or approximately four percent of the CSHCN budget.

#### Infrastructure Building Services.

Estimated expenditures for continuing development of core public health functions and system development are \$4,907,026 or 33 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 31 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child health systems development consultation. CHSC's budget for infrastructure building services is estimated at \$844,399 (17 percent of the CSHCN budget).

Other federal funds directed toward MCH include:  
State Systems Development Initiative;  
Early Childhood Comprehensive Systems Grant;

Medical Home Initiative for Children with Special Health Care Needs;  
Title X Family Planning;  
Abstinence Education Initiative- Section 510;  
Early ACCESS (IDEA, Part C); and  
Early Hearing Detection and Intervention (CDC and HRSA).

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.